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Neuropsychiatric Nursing

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Requests for information and advice regarding neuropsychiatric training for nurses have been so numerous that I am going to select a few of the most persistent questions and try to answer them. These requests come both from graduate nurses desiring to take post-graduate work in neuropsychiatric nursing and from young ladies contemplating a course in nursing.

I shall try to answer the following questions:

(1) Where can one take a post-graduate course in mental nursing? Can you tell me something about the course?

(2) If one is particularly interested in mental nursing, should one train in a mental hospital and then take some work in a general hospital, or should one train in a general hospital and then take a post-graduate course in mental nursing?

(3) What qualifications does mental nursing demand?

(4) What is the outlook for nurses with a special training in mental nursing?

It is regretted that up until very recently there has been no well organised post-graduate school for neuropsychiatric nursing operating in Canada. A few general hospital graduates get positions in our mental hospitals as instructors, etc., and in this way get some experience. I understand that a one-year post-graduate course in neuropsychiatric nursing will be offered at the Ontario Mental Hospital at Whitby, Ontario. The outline is attractive and follows fairly closely a course which is outlined in this paper. The medical men associated with it are enthusiastic and progressive. The institution is large and modern. The fact that it is in our own country and that nurses taking the course will most likely receive lodgings and pay should make it especially attractive. They will not be able to take a great many, but it is a start in the right direction. If the mental hospitals do put on such a course there should be a good deal of mutual benefit. The efficient graduate nurse, trained in a general hospital, would help to raise the standard of general nursing in the mental hospitals, and she in return would beceive her special training.

If we had general hospital nursing courses reduced to two and a half years and then followed by a year's training in an active mental hospital there would, in all probability, not be the unemployment and hardship that so many nurses are enduring just now. Some of this may be due to the fact that in the not distant past a girl without much education could go into a mental hospital and train for three years and receive fairly good pay during her course. Then she would put in a few months in a general hospital, after which she could go out and compete with nurses who had put in three hard, unremunerative years in a good general hospital.

In the meantime there is a well-organised post-graduate school in neuropsychiatric nursing being conducted at the Veterans' Hospital, Bronx, New York. This has been established by the United States Veterans' Bureau to meet the increasing demand for nurses with psychiatric training. Lectures are given by the

doctors of the staff on the anatomy, physiology, and pathology of the nervous system. In the psychology course the correlation of structure and behaviour, emotions and instinct as driving forces in human behaviour, the rôle of intelligence, stream of consciousness, complex dissocation, rationalisation projection and mental conflict are subjects touched upon. Views of the leading psychologists on personality, psychoanalytic views, sex hygiene and the behaviour problems of children are presented. Lectures and demonstrations on clinical psychiatry, adequately covering all mental diseases, are given. Special lectures and demonstrations are given by the members of the hydrotherapy department. Of course, this includes instruction in the application of wet packs, continuous baths, and other forms of sedative treatment. There are lectures on occupational therapy, which include demonstrations in all the crafts, and illustrate the benefit of each on the different type of patients. The therapeutic value of occupation as it applies to all mentally sick people is emphasized.

They have the opportunity of studying the home conditions of the patients. The home is visited and prepared for the patient's return, and the patient goes home feeling that he has the support of the social service workers.

The nurses, along with the aides and social workers, attend the staff conferences. They hear the histories read and observe the method of examining the patient. In addition, the nurses visit the Psychiatric Institute and Hospital in the great medical centre, 168th Street and Broadway. This institution is planned, equipped and staffed to conduct special research, investigations into the cause, nature and treatment of all mental abnormalities and to aid all those who are caring for mental diseases to affect more efficient preventive and curative measures.

They also visit the Bloomingdale Hospital, where tremendous sums of money have been spent in making the patients' surroundings beautiful as well as comfortable.

Had this question number two been put to me five years ago it would have been more easily answered. Conditions are changing somewhat. During the past year or so the Ontario mental hospitals have come under the Minister of Health—a medical man. It would appear that he is endeavouring to make them scientific, up-to-date hospitals. The old idea that any expense beyond custodial care is unjustified is, we hope, gone forever. Most of these institutions are well equipped and staffed to take care of all medical and surgical work that may arise among their patients. In many cases the general nursing instruction is given by competent general hospital graduates or by mental hospital graduates who have taken post-graduate work in general hospitals. Medical men are doing more research with the aim of finding both preventive and curative measures. Occupational therapy and social service work are being actively developed.

Some of the Ontario hospitals are so fortunate as to be situated close to medical schools. These have a decided advantage not only in regard to research work, but in the matter of good general clinical work in medicine, gynæcology and surgery. Such hospitals would seem to be excellent points at which to establish post-graduate schools in neuropsychiatric nursing. At any rate, the nurse who trains in one of the above hospitals and then takes a year of post-graduate course in a good general hospital should be able to meet all nursing requirements.

While the above advances are being made in the mental hospitals, the best general hospitals, realising that a knowledge of psychology and psychiatry helps nurses in their everyday work, are making an effort to give their classes lectures covering the above subjects. In some cases it is convenient to take these classes into mental hospitals to receive lectures and study cases. Some general hospi-

tals are developing a neuropsychiatric division, staffed and equipped to care for temporary, mild and early mental trouble. In this way nurses in training will get an opportunity to test their adaptability to neuropsychiatric nursing.

The recent development of travelling mental health clinics could be made to help general hospitals very much, both in teaching and in drawing clinical material, because naturally psychiatry cannot be taught apart from the mentally sick patient.

As regards qualifications, one must consider educational and personal qualifications. A young woman should have at least three years' high school training, or better still, be a graduate nurse. A good home training with an appreciation of good music, literature and art make an excellent background. She is armed with an ever-ready means of entertaining most patients and will be the more acceptable in cultured homes. No nurse can read and appreciate Dickens without being the better for it. Otherwise she is not likely to carry the course without difficulty and make a creditable showing in her R.N. examinations at its conclusion.

She should be sound in mind and body. Great size and strength, once considered so essential, are not stressed nowadays, since she who would use them to control a patient has no place in psychiatric nursing. The young woman with a pleasing personality, a good digestion, ability to sleep, and good recuperative powers after fatiguing duties is more in demand. No branch of nursing is more trying, nor does any branch demand such a thoroughly sympathetic understanding, so much self-confidence, self-reliance and control, resourcefulness, tact and diplomacy. She must be strictly truthful: most mentally sick people despise deceit and lying. She must always be the untiring patient's friend, protector and advisor. She must realise that mentally sick people are not accountable for their behaviour and that they act as they do just because they are mentally ill. She should be quiet in speech and manner. The snappy, irritable type of young woman should never attempt a course in any kind of nursing. Most of the mentally sick people are hypersensitive—a sharp, grating voice, glaring lights, jangling keys, slamming doors, squeaky shoes often give unnecessary pain. Sometimes in spite of her best efforts she will get slapped, insulted, and perhaps have her hair pulled; and yet I have never heard a graduate in mental nursing say that she regretted having chosen the work.

The field for the nurse with a training in neuropsychiatric nursing is gradually broadening and will continue to do so. Along with a better understanding of mental illness by physicians, nurses and the public is the awareness that there is a mental aspect to almost every illness. Many medical and surgical patients are irritable, peevish, restless, impatient, or perhaps mentally depressed. The nurse who cannot appreciate the mental aspect of all this is likely to get into trouble and too often it is not altogether her fault. Physicians around a general hospital soon find out what nurses seem to get on well with difficult patients. The tragedy here is that so very few are born psychiatric nurses and the rest are out of luck for lack of training.

Each year sees an increased effort put forth by the Government to take care of sick people: mental health clinics provide openings, the National Committee of Mental Hygiene is gradually increasing its activities, and it is only a matter of time until school and industrial nurses will be required to have special training along this line.

It can be said, without any fear of contradiction, that the successful nurse of tomorrow must be an intelligent, sympathetic woman, equipped with a sound training in both general and neuropsychiatric nursing.

Editorials

PREPARATION FOR PSYCHIATRIC NURSING

In recent years there has been discernable, in discussions of nursing education, a trend toward including in the curriculum of schools of nursing, experience and instruction in psychiatric nursing. A recognised drawback to development of this type of nursing in Canada has been the lack of established and systematic organisation in mental hospitals, as is found in general hospitals, for the teaching of nursing. Quietly but effectively for a period of years medical men and nurses, active in the care of the psychiatric patient, have been inducing state health and welfare departments to allocate larger budgets to mental hospitals, until now in some provinces, if not in all, these institutions have progressed to the point where both undergraduate and graduate nurses can be assured the right type of training.

At the present time it is encouraging to learn that improved developments in our mental hospitals lead us to be assured that in future our nurses can obtain in Canada an adequate training in the care of the mentally ill. Those who have pioneered in this special field of nursing are to be commended for their perseverance. May they be rewarded in seeing from year to year an ever increasing number of graduate nurses with a knowledge of the theory and practice of the many aspects of mental hygiene nursing.

In Dr. Baugh's article on Neuropsychiatric Nursing in this issue of the Journal he first asks several questions pertaining to this type of nursing, then he proceeds to answer those questions. In doing so, there is presented in concise language the educational and personal qualifications necessary for the young woman who contemplates becoming proficient in caring for the mentally sick patient and in promoting the spread of the principles of mental hygiene throughout the community. The article closes with what may be termed a word of warning when it states the belief that it is only a matter of time until school and industrial nurses will be required to have special training along this line, and that the successful nurse of tomorrow must be an intelligent, sympathetic woman, equipped with a sound training in both general and neuropsychiatric nursing.

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HON. VINCENT MASSEY

THE Programme Committee are to be congratulated on arranging a very remarkable programme for the Saint John meeting. One needs only to mention the fact that the speaker of the first evening is the Hon. Vincent Massey. When Mr. Massey turns his mind to the problems of nursing, he will make a contribution that no nurse in Canada can afford to miss.

It may be that governments have "forgotten the nurse" in general schemes of state education, but when great public men such as Mr. Vincent Massey come to the assistance of the nursing profession, there is hope that the recommendations of the Survey Report may be put into effect in the not too far distant future.—J. E. B.

Taking the Profit Out of Nursing Education

By E. P. LYON, Ph.D., Dean, University of Minnesota Medical School, Minneapolis

[EDITOR'S NOTE: With the publication of the Weir Report of the Survey of Nursing in Canada, Dr. Lyon's article, reprinted from the November, 1931, issue of *The Modern Hospital,* is of peculiar significance.]

Since under the organisation of the University of Minnesota the nursing school is part of the medical school, the dean of the medical school ought to know something concerning nursing education. Through necessity, therefore, I have studied nursing education, read about it, talked about it with many people and latterly have sat at the knees of our Miss Densford, like a dutiful child, for many an hour.

I have found that nursing education is an elusive and complicated pattern. I confess that even now I do not know much about it, but I shall venture to express certain opinions.

One thing to which I have directed my mind is the organisation and control of nursing schools. I find that they are adjuncts of hospitals, that few of them have any relation to other types of organised education. Well, medical schools also are organised in relation to hospitals and depend on hospitals for indispensable facilities. But here I find a most significant, a most crucial difference. The doctors control the schools of medicine, the nurses do not control the schools of nursing.

The nursing schools are not in the hospitals because the hospitals have a high sense of educational responsibility, but because the hospitals have patients to be cared for and can secure this care cheaper by having training schools than they can without. A hospital recognises as its primary function the care of the sick. If, incidentally, the hospital can aid education it is willing to do so, provided it does not cost the hospital anything.

Ask any hospital superintendent, ask any hospital trustee whether he would continue to maintain a training school if it cost the hospital more than the service of the pupils is worth. I venture to say that ninety-nine times out of a hundred the reply will be "No." Such a reply would be dictated not by lack of interest, but by lack of money. It is hard enough to keep the average hospital going. Few of them make money; most of them are money eaters, not able to live on what the patients pay. They run training schools to save money.

These two facts—that nurses do not control their educational institutions and that hospitals do control them and run them to save money—are at the basis of nearly all that is wrong with nursing and with nursing education.

Who Gets the Money that Is Saved?

The training schools save the hospitals money. That is what we say, and we condone the whole situation on that ground. When money is saved, however, someone saves it or, let us say, gets it. A bank does not save money for its customers. It is the depositors themselves who saved the money that is in the bank. If a corporation saves money, it goes eventually to the owners of the corporation. Now who gets the money that the hospitals save by having nurse training schools? This is a vital question.

No one, of course, takes cash out of the hospital till and transfers it to his own pocket, but this is the way that an equivalent transfer is accomplished. Suppose a private hospital doing a certain amount of charity service has to raise $50,000 a year in donations from its wealthy clientele. If the nursing school saves this hospital $10,000 a year the school is

really giving the hospital $10,000 that otherwise it would have to solicit from its wealthy friends. The work of the nursing students leaves $10,000 in the pockets of the rich patrons of the institution that they would have to give up if the institution were to continue on the same scale. The rich pay less for the privilege of being patrons of the hospital and for the wholesome feeling of being benevolent than they otherwise would.

Or let us suppose that an institution is living on its receipts from patients, neither losing nor making money. If the training school saves the hospital $10,000 that it would otherwise have to take in and spend in order to break even, then the patients are profiting from the training school, because if it were not there the patients would have to pay a higher rate. The patients get the $10,000.

Or look at a public hospital, a city hospital supported by taxes. The governing board or city council appropriates as little as will maintain the hospital on such a scale as the community approves. If the training school saves that hospital $10,000, it is saving taxes. No wonder the city fathers approve of the city nursing school. All other city schools cost tax money, eat up a large proportion of tax money. Here is one type of education that not only costs nothing but saves taxes for other purposes. If I were a councilman I would say, "Let us by all means have more and larger nursing schools. If we only had enough such schools we could support the whole city government, including public schools, and abolish all taxes."

There is only one more possible case, the almost unknown one in which the hospital makes money. If the nursing school saves $10,000, the owners get $10,000 more in dividends than they otherwise would.

The Fundamental Defect

The training schools save the hospitals money. The money that is saved goes in the long run to patients, to philanthropic donors, to taxpayers or to owners or some combination of these, on the assumption, always, that the hospital is conducted on the same scale whether or not it has a training school. In any case the saving does not go to the nursing students or into their education. This is the fundamental defect of nursing education, the fundamental injustice that is being done to the nursing profession.

Nursing education will never be as efficient as it should be nor will it occupy the honourable status it should until the profit is taken out of its educational institutions. Profit is all right in business, at least so says our social philosophy, but in education it is wrong in principle and always has a bad effect on the quality of instruction supplied.

Nurses will never be able to control their educational institutions, they will never be able to regulate the number of such institutions, the character of the curriculum, the hours and type of practical experience, the kind and number of candidates admitted or graduated until the profit is taken out of nursing education.

The Grading Committee made a serious mistake when it stated in Part 3 of its report that there is no objection to hospitals making money on their training schools if the education provided is satisfactory. There is some saving grace in the proviso, for those really acquainted with education know that a fully satisfactory course cannot be supplied from the simultaneous earnings of students. Nevertheless, the statement is reactionary and will open the way for specious arguments for the continuation of the present system. The profit, all the profit, must come out of nursing education before the nurses can control and vivify their educational processes.

Too Many Schools!

A second result, as I have just implied, of the ownership and control of nursing schools by hospitals is that there are far too many schools. I was amazed recently to learn that they

number about 2,200. Over two thousand nursing schools in the United States and seventy-six medical schools! Twenty-two thousand nurses graduated in 1930 to join the ranks of the unemployed! The situation would be comical if it were not tragic.

When medical education was at its worst, about twenty-five years ago, there were 160 medical colleges, far too many and many far too poor. Even at the worst, however, these schools were controlled by medical men, amenable to medical opinion, influenced by medical tradition. When the profession as a whole, through the Council on Medical Education and Flexner Report, became aware of the conditions in medical education, self-respecting doctors could no longer run or remain connected with a profit-making college. An era of closing poor schools, of mergers and of transfers to universities ensued. In a few years the situation was changed completely. But in nursing, the building of new hospitals and the founding of new nursing schools goes merrily on. The more hospitals, the more pupil nurses, the more graduate nurses. But the more hospitals, the fewer sick persons outside of hospitals, the narrower the field for the graduate after she is out. Undoubtedly this is true in spite of the larger number of sick cared for by trained nurses now as compared with former times.

Suppose every business or industry needing ten or more stenographers should say: "We will have a stenographic school; we will have the president's secretary do the teaching (that will cost us nothing), the vice-president's and treasurer's secretaries will help (also without expense to us); we will keep our pupils three years and after the first six months expect them to do full work—including Sundays; we will give them board, lodging, laundry — and a swimming pool; at the end of three years we will have a little celebration, perhaps in a church, and give each one a cheap gold pin; we will then take in a new group of girls to do our work; we will recommend our graduates to people who need stenographers; regretfully we may hire a few ourselves when we can't get student stenographers enough." Imagine the condition of affairs in the stenographic profession! And isn't this a fair if somewhat high-lighted picture of nursing education as it actually exists at the present time?

What Pupil Nurses Earn

How much do the pupil nurses earn —how much do they save for the patient, the philanthropic donor, the taxpayer, the owner? Few studies have been made, and most hospitals do not know. Phoebe Gordon, an instructor at the University of Minnesota School of Nursing, has studied this matter for the University Hospital and for the Miller and Northern Pacific Hospitals, St. Paul. Her figures, which no one has disputed, show that if the pupil nurses were allowed 35 cents an hour for their work after the preliminary period, each one would earn between $100 and $150 a year over and beyond all that is expended for her board, lodging, instruction and every expense connected with her education. Be sure to get this straight: if the hospitals paid these girls 35 cents an hour, which is less than one usually pays a maid, and then if each girl paid back to the hospital and to the university every cent that is spent on her for education, maintenance, uniforms and even her graduation pin, nevertheless the girl would take away with her at least three hundred dollars in cash when she graduated. What really happens is that she takes away a piece of paper called a diploma and leaves that $300 behind in the pockets of the patients, the taxpayers, the philanthropists and the owners.

This $300—if that be the right figure—that is earned by each student nurse during her course, if spent on her education, would entirely change the character of nursing education. Even then the student would be earn-

ing her entire education; it would cost the hospital nothing, the public nothing. Point to any other example like it if you can.

As a parallel case I studied the dental college at the University of Minnesota. Under supervision and instruction, the students do dental work for patients who come to the college. The university collects small fees for such a service. I find that the receipts for last year from this source were about $50,000, while the material used amounted to about $30,000. The difference, $20,000, may be looked upon as the earnings of the students. What became of this money? It went to help support the dental college, that is, it went toward the education of the students who earned it, and with it went $47,000 collected from the students for tuition and about $63,000 of university funds. By university funds I mean tax money appropriated by the state legislature.

In the same year the pupil nurses at the University Hospital saved the hospital around $20,000 above all expenses for maintenance and education, if their time is calculated at 35 cents an hour. Did this amount go into nursing education, as the dental students' earnings went into dental education? It did not. It saved the taxpayers of the state of Minnesota that much, or it saved the patients that much. Not a cent of it went into nursing education. Yet we speak of a "university" school of nursing!

I recognise the fact that our hospital could not have paid more for nursing education last year than it did—the appropriation for the hospital would not permit it—nor did we feel able to raise the fees of the poor people who came there. We are victims of the tradition, the stupid, selfish tradition, that provides that profit from nursing students must go to support our patients. This does not alter the fact nor modify the glaring contrast between the state's support of dental education on the one hand and the support of the state's hospital through nursing education on the other.

Some of my friends view the situation with equanimity. They say that others are exploited besides pupil nurses; that internes are exploited; that assistants and young instructors in the university are exploited. They talk of the valuable diplomas the nurses will get. They point to the advantages of training school life, speak of the protection afforded young girls during formative years, extol the habits inculcated, dilate upon the excellent (?) preparation for marriage, which will be the ultimate state of many of the nursing students. They talk a good deal like our pro-slavery ancestors, who were wont to condone slavery by speaking of the many masters who protected their slaves and treated them kindly.

Comparing Nursing with Other Education

I can't understand this point of view. The fact that in all other forms of education (at least for all students who are to engage in service as contrasted with business) more is spent than the student pays, while in nursing education the student earns more than she gets as education, revolts my feelings of justice and I want to do something about it. I ask myself, "Can anything be done?" I go over the cards the nurses hold with a view to seeing what their chances are of winning the game and securing what they earn and using this money for more adequate educational opportunities. The hand is not strong and there are few trumps.

The Ten Spot in the Nurses' Hand

First, there is the Grading Committee. I place the Grading Committee not higher than a ten spot at most in the hand the nurses have to play. The committee is too timid, too lady-like. Contrast its confetti pronouncements with the bombshells of the Flexner Report on medical schools. "Everything you tell us," says the Grading Committee, "will be regarded as confidential." Where-

as the Flexner Report fired broadsides in public print like this: "This school is one of the worst in the country"; or again, "At the date of visit, there was no outfit at all"; or again, "The clinical facilities are wholly inadequate"; or "This school is a wholly helpless affair." Your Grading Committee tells us what you already know about your own school and little about other schools.

Moreover, the Grading Committee has engaged itself with statistics and charts when what it needed was to hire a battery of artillery. The committee makes much of its fact finding and then naïvely acknowledges that the essential facts were already available, for example in the Rockefeller Report of 1923. Indeed, the facts are transparently visible to everyone who has eyes to see. Why collect statistics that there are too many nurses? When the average graduate has only five days' employment per month, as in Minneapolis, we do not need statistics, we need something done about it.

Among the forty or more recommendations of the Grading Committee there is no hint that the first necessity is to take the profit out of nursing education, no recognition that this is the vital point in the whole issue.

In spite of its enthusiasm and hard work, I don't think the Grading Committee will be highly effective, and when the hand is played out not even ten spot value is likely to be realised.

Then there is the card called propaganda, the creation or education of public opinion. Of course, the efforts of the Grading Committee are partly educational and are good as far as they go. I believe, indeed, that the general public is gradually getting a truer view of the situation in nursing. Some public interest has been shown, for example, in the paragraphs in *Time* for September 14, 1931. But the facts have been known to hospital superintendents, many of whom are nurses, for a long time. These superintendents are the real dictators of the schools, yet nothing has been done. My guess is that nothing will be done until the situation is forced.

This condition had its parallel in medical education. From 1890 on medical educators and the Association of American Medical Colleges knew the weakness of medical education, and many individuals worked hard to improve conditions both in their own colleges and in the country at large, but the roots of a vicious system could only be blasted out when the organised medical profession and the Carnegie Foundation exploded the dynamite of the Flexner Report.

The organised medical profession could explode and did explode that dynamite. Can the nurses do the same thing? I am afraid not. Their lady fingers are not accustomed to handling explosives. Furthermore, I am afraid that some doctors, not understanding the situation, may keep the nurses' hands tied. I give educational efforts about a six spot value.

But the nurses do control the teaching in the sense that they are the only teachers available. If they were able to present a united front, if they could bring themselves to declare a moratorium in nursing education, if they would say "no more apprentices for so many years," as the carpenters or bricklayers or locomotive engineers would say in similar circumstances, and if they would hold to such decisions—no scabs in their group—then something would happen and it would happen quickly.

But you say, "Oh! we couldn't do that! There are the patients to be cared for. That is our glorious tradition. That is our first duty."

Dear misguided ladies! Do you not know that if you issued an ultimatum that after January 1 there should be no pupil nurses in any hospital anywhere, the patients in those hospitals would be just as well cared for as they are now? Do you not know that the philanthropist, the patient, the taxpayer and the owner would find the money you have been saving

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for them? Do you not know that the nurse students would be promptly replaced by graduates who are idle at the present time? If you do not know these things then you do not know the tremendous strength that is yours if you saw fit to use it and could act solidly and as a unit in fighting this battle.

Will Nurses Heed This Plea?

Can you not feel the terrific public appeal of such a slogan as "No more nursing students until the profit is taken out of nursing education?" And the interesting fact is that not one of you would go to jail. Not one superintendent of nurses, not one supervisor would lose her job. The hospitals would have to keep you, for your primary work is caring for the sick and not teaching. All that this programme needs is courage.

There is talk of cutting down the production of cotton, of wheat, of various crops of which there is an unmanageable surplus. Why not cut down the crop of nurses? I'll tell you why. Because the profit in nurse farming is not in selling the crop, but in growing the crop. We leave the crop to sell itself, if it can. Why not have more consideration for the crop? Why not plow in nine rows out of ten, or stop production altogether for a while?

Trade Union Methods Suggested

If hospital superintendents had to sell their nurse graduates to get their profit—that is, find each one a job—these superintendents would have run to the Farm Board long before this. They would want the Government to take the whole crop off their hands. As it is, the nurse teachers are the only ones who have power to limit nurse production, and the nursing profession, not the hospital superintendents, has an interest in so doing.

But you are timid, you are not solidly organised, you are poor. You say you cannot use trade union methods, forgetting that the doctors, the lawyers, even the college professors, have union though called by other names. On your power to control production through withholding nurse teaching I give you about a five spot rating compared with the ace that the American Medical Association played when it declared itself in favour of two years' pre-medical college work and formulated the minimum standards for an accepted medical school. The ace took the trick, forced the game. The five spot—well, it could grow to be an ace if you so willed. If you so willed!

The nurses control, I assume, the standards of admission to their own societies. I assume that these bodies could decree that after a certain date no one could secure membership who had been trained in a hospital that made money on its nurse students. I assume that they could declare that no one might retain membership who accepted employment in such a hospital. But I know they won't do any of these things, and I give a four spot value to all that organised nursing will do in a positive way to improve pressent conditions.

The nurses control or seem to control the boards of nursing examiners whose fiat turns the graduate nurse into a registered nurse. These boards could enforce, or it seems as if they could enforce, rules regarding recognition of acceptable schools. They could refuse to recognise graduates of schools that make money on nursing education, schools that exploit their pupil nurses. The boards of medical examiners define acceptable medical schools and refuse to examine graduates of non-acceptable schools. Could the boards of nursing examiners do the same? Possibly, but my guess is that they could not present a united front for such an end and that, if they did, they would meet opposition from certain medical men, honestly doubtful, most of them, as to the value of nursing education. However, this card has possibilities and I value state board influences as a nine spot, at most, in the hand the nurses have to play.

These are your cards. What can you expect in your partner's hand? The interesting thing is that you don't know just now what partners you may have, but there are intriguing possibilities.

There is the American Medical Association. I understand that the American Medical Association is not participating in the Grading Committee's work. Still, I cannot believe that the association will keep completely out of a game in which so much is at stake for its age-long ally, organised nursing. If I were you I would put on my prettiest smile and try to vamp the American Medical Association on the crucial point of squeezing the profit out of nursing education. The doctors are honourable and intelligent. They have only to recall the days of profitmaking medical colleges and the educational havoc that resulted. They are eminently just when they understand a situation. Just now they are inclined to condone the present system because it has existed so long. Who knows, if they get a true view of the conditions but they may be brought into the game with all their strong cards, such as approval of hospitals for internships? Think of the rattling of dry bones that would be heard if the Council on Medical Education and Hospitals would announce that after 1935 there would be no approval for internship in a hospital that make a profit on its student nurses!

The A.H.A. as a Partner

There is the American Hospital Association, composed largely of those terrifying dictators of nursing education, the hospital superintendents. But of course they are not really terrifying. Rather they are your friends. They, like the rest—doctors, nurses, the public—have been victims of tradition. The superintendents are not entirely free any more than you are entirely free. They are responsible to trustees and political influences. They may not relish the prospect of having to raise from none too prolific sources the money needed as a substitute for what the pupil nurses earn. But if they had to raise it they could and would do so. Perhaps the American Hospital Association might be induced to pay such a tremendously potent card as : "No membership for hospitals that make a profit on nursing education."

The American College of Surgeons possesses enormous power. Can the college be induced to pronounce the vital principle, "No profit in nursing education," as one of its criteria for approval of hospitals? What a card if they will only play it! Even the bluff of playing it would win the game.

These, as I see it, are the cards you hold and the cards your partner may hold. Now what cards have your opponents? Yes, they have a strong hand.

First, there is tradition. Nursing education began as an adjunct, an ancillary function of the hospital. (I looked up that handsome word ancillary and found that it is derived from the Latin word for female slave.) The nurse students have always served the hospitals free. The tradition of free service will be a hard one to break.

Can Nurses Stop Giving Free Service?

I should like to live a hundred years more for just two reasons: first, to see whether the nurses can break the tradition of free service—in other words, whether they can collect from the philanthropist, the taxpayer, the owner, and the patient the money that rightly belongs to them for their education. Second, I should like to live long enough to see whether the doctors can break the equally vicious tradition that they must take care of the poor for nothing. The public, the taxpayers, should be responsible for the sick poor and should pay the doctor, and the nurse also, for services to the poor, just as they pay for their beds, food, fuel and shelter.

A second card your opponents hold is vested interest. They have lived on it for many years. It will be hard for them to give it up. They will have to raise in some other way the money they have "saved" on their training schools. The philanthropist, the owner, the taxpayer, and the patient will not voluntarily regurgitate. Will you use an emetic strong enough? I have shown you one, but I doubt whether you will administer it. You will wait, I presume, for a doctor's prescription. If so, you will wait.

A third card in your opponents' hand is the psychology of the position you occupy in the hierarchy of healing. Your position is exactly described by the word ancillary. Individually you are accustomed to take orders. Your initiative is limited. Your rank and file look to the medical profession rather than to organised nursing for canons of action. I am afraid that this card will cancel the value of all the trumps you hold.

However, the game is on, put on a poker face and play your best, and I for one shall watch with much interest the fall of the cards. You deserve to win, and I hope you do win.

This address is intentionally dogmatic and provocative. I am aware that things I have said are not true in particular instances and situations, but I have purposely avoided the particular and the exception. On the other hand, as you all see, there is nothing new in this address—no new facts, no new thought unless it be the analysis of who actually profits by the earnings of the nursing students. The newness, if any, is in emphasis. Of all the difficulties and shortcomings of nursing education I claim that the basic casual factor is the profit in it. I claim also that practically all criticisms of nursing have the same cause. I presume to make a diagnosis. The nurses as expert therapists should take upon themselves the responsibility for treatment. Others may assist but, as I see it, the nurses must be responsible for it, must do most of the work.

I have put forward as a leading thesis the claim that the trouble with nursing education is the profit hospitals make out of it. As I see it this is responsible for the number of schools, far in excess of the need; for the over-production of nurses; for the poor quality of many students of nursing and for the many incompetent graduates; for the unsatisfactory curriculum adjusted to hospital needs and low grade students and not to the educational requirements of superior women; for long and health-destroying hours of duty; for a condition of affairs in which, in many instances, one cannot distinguish between the R.N. and the practical, because one is as good or as bad as the other.

Let Nurses Control Their Schools

Take the profit out of nursing education. Give the nurses control of their own education. Under such circumstances they could determine how many schools they need and make their contracts with suitable hospitals willing to co-operate in nursing education. If a hospital will pay its co-operating school all that the students earn in service, that hospital will be no worse off and of course no better off than its neighbour hospital that has no school and hires graduate nurses. The incentive for multiplying schools will be gone. The proper number and quality of nurses will be trained and these, when graduate, will find employment. The whole situation will become sane and dignified. With sanity and dignity will come in time, I sincerely believe, as they did to medical education, the endowment and public support needed to raise nursing education to the level of the other professions as far as culture, scientific background and intellectual average are concerned. Take the profit out of nursing education and all else to be desired will come into it. This is my thesis, my diagnosis.[1]

([1]Read at the meeting of the Minnesota State Registered Nurses Association, September 24, 1931, and the Illinois State Nurses Association, Chicago, October 15, 1931.)

Some Features of the Report of the Survey of Nursing Education in Canada

(As released to The Canadian Press, February 12th, 1932)

The Survey of Nursing Education in Canada was initiated and, for the greater part, financed by the Canadian Nurses Association in co-operation with the Canadian Medical Association. This action was taken in order to get at the facts of the nursing situation in Canada.

In 1927, the Canadian Nurses Association and the Canadian Medical Association appointed three representatives each to form a National Joint Study Committee. This committee was entrusted with the responsibility of devising ways and means for undertaking the Survey. The committee decided that the Survey must follow scientific methods and that it should be made by a specialist in education. Professor G. M. Weir, Professor of Education in the University of British Columbia, who, some years ago, conducted a Survey of Education for the Government of British Columbia, was asked to make the Survey of Nursing Education. Fortunately, the Board of Governors of the University of British Columbia, realising the necessity and importance of this work, were good enough to give Professor Weir leave of absence for almost two years in order to undertake it.

The completed report deals with many angles of nursing education and nursing practice. The committee now submits the whole report to the careful study of the nursing and medical professions and to the general public, trusting that it may form the basis upon which will be built a constructive plan for the improvement of the nursing service in Canada.

The following headings will give an idea of some of the most important aspects. The recommendations are Dr. Weir's and are printed as a basis for discussion:

I. *Economic.*

The whole question of nursing education is bound up with the finances of the hospital. The opinion commonly prevails that the training school for nurses provides cheap nursing for the hospital; hence the protests of small, inadequately equipped training schools against closing their schools and staffing their wards with graduate nurses. The Survey has some interesting facts to present on this problem, based on a study of costs in 33 representative training schools — 9 small, 15 medium size, 9 large—well distributed throughout Canada. The fact is that under present conditions there is an annual loss to the average hospital in Canada for each student that is receiving a satisfactory training in nursing. But in a number of the cases of small schools brought to the attention of the Survey, their pretence at offering an educational course of training should be considered little more than mere sham.

The necessity emphasized throughout the report is that training schools for nurses should no longer be left to the haphazard methods of individual hospitals, but should be subsidized, controlled and supervised by the Government in the same way as normal schools are. An approved training school should be defined by law, and hospitals, otherwise qualified, should not be legally authorised to establish training schools unless on the explicit written statement of the Provincial Board of Control.

To quote from the Report in regard to the necessity of subsidizing training schools for nurses:

"Surely the state is no longer justified, in the face of unimpugnable

facts, in complacently standing by and ignoring its duty to contribute to a great national enterprise—namely, the education of the student nurse. . . . There is no more valid reason, when all the facts of the situation are impartially weighed, why, for instance, the state should pay the costs of normal school education than that it should pay the cost of educating student nurses. It is admitted that the state is justified in insisting upon adequate standards of nursing education, involving efficient inspection and supervision of the nurse in training and in service, as a condition precedent to the granting of financial assistance. And such competent supervision, kept clear of all partisan influence, would be welcomed by the true friends of nursing education. . . . From a financial viewpoint, nursing education should be made an integral part of the provincial educational system as is the education, for instance, of the teacher. . . . Furthermore, it is scarcely subject to serious doubt that the adequate training of the nurse is at least as complex as that of the teacher. Fully as much laboratory equipment and library facilities, for instance, should be available for the professional education of the former as for that of the latter. The quality of the instruction in each case should be reasonably equivalent. That this relative equality by no means exists—with the exception of certain nursing schools in medical centres or university courses for public health nurses—will be manifest to anyone who impartially studies the situation. From the viewpoint of teaching facilities and equipment as well as quality of instruction, the standards obtaining in the average training school for nurses in Canada are distinctly inferior to those found in the average high school or collegiate institute, not to mention the average normal school. As a matter of fact, the full-time instructor, even in the best type of training school for nurses, is a comparatively recent innovation. . . . Poorly equipped schools for the training of doctors, lawyers, or teachers are no longer tolerated. And there is no valid reason for the training of nurses being placed in a different category. . . . To use Lord Durham's classic stricture in a new setting, the nursing profession cannot 'remain an old and stationary society in a new and progressive world.' ''

II. *Educational Standards.*

The Report points out the glaring disparity between the best and weakest schools in regard to

1. *Preliminary Education.*

In some of the small schools, students with only grade VI. standing (elementary schools) are found. In the large schools some university graduates are enrolled—yet all are preparing for the same R.N. examinations.

The requirement of two years of high school, specified by most Registration Acts in Canada, is frequently flouted or ignored.

2. *The Content of the Curriculum* as between the poorest and best training schools shows great variation, such as would never be tolerated in high schools or normal schools.

3. *The R.N. Examinations* are, on the average, a sieve with wide meshes.

The failures on the departmental examinations (conducted by the various provincial departments of education) are, in percentages, about four times the failures on the R.N. examinations, yet the former are educationally very reasonable.

The methods of marking the R.N. examination papers show wide variabilities as shown in the Report. For instance, in an experiment conducted by the Survey fifteen experienced examiners (who teach in training schools) awarded percentages ranging from 11 to 58 for the same examination paper.

4. *Lecture Method in the Classroom.* In the average training school, this methods usurps about 75 per cent. of the time given to instruction. Students are ''lectured at'' more than they are taught.

5. *Housemaid's Work,* which after the first six months or so has lost its educative value in the actual nursing training, accounts for nearly 37 per cent. of the student's time in the average training school. This means work that a housemaid could be reasonably trained to do.

6. *Size of Hospital Conducting a Training School.* The minimum size, according to medical and nursing evidence, should be 75 beds with a daily average of 50 patients. Closure of schools under the above size would reduce the number of student nurses by 13 per cent.

7. *Theory and Practice.* Medical and nursing evidence shows that too much time, in an absolute sense, is not given to theory in the training school, but that much of the curriculum in general should be subject to revision. Practice should not be increased at the expense of properly selected theory.

III. *Over Supply of Nurses.*

At present there is no correlation between the needs of nursing services and the supply of nurses being turned out. The hospital hands each of the members of the graduating class a diploma, wishes her God-speed, and feels no further responsibility. It doesn't matter how serious the unemployment problem may be: the hospital takes in its same quota of student nurses each year.

At the time the field-work of the Survey was completed (autumn of 1930) it was estimated that there was a surplus of graduate nurses in Canada—with the exception of public health nurses and full-time instructors, of whom there is a shortage—of about 40 per cent. It is a serious and critical situation that about 40 per cent. of the private duty nurses in Canada as a whole are almost continuously unemployed; about another 20 per cent. are only intermittently employed.

IV. *Distribution of Nursing Services.*

Although 40 per cent. of private duty nurses are constantly unemployed, the amazing fact is disclosed by the Survey that 60 per cent. of the cases of average acuteness (not colds or minor illness) in Canada are reported to be cared for by non-trained attendants. A density and distribution map shows in graphic form that 25 cities, which account for one-third the population of Canada, have the services of about two-thirds of all active registered nurses.

There is also evidence that only three out of eight patients of moderate means who need the graduate nurse are able to engage her. Hence the need for a socialisation of nursing service.

V. *Socialised Nursing Service.*

There is a growing dissatisfaction throughout Canada with the high cost of health services. Unthinking people have blamed this on the nurse, but now an informed public sentiment is looking towards some form or method of socialising health services. Socialisation would largely bridge the gap between the needy patient, unable to pay graduate nursing fees, and the unemployed graduate nurse, unable to market her services in over 60 per cent. of the cases of illness.

In its analysis and advocacy of the principle of socialisation of nursing services, the Survey emphasizes the following points:

1. *The principle of ability to pay.* There should be no pauperising; at the same time an effective socialisation of health services should supply these services to the average patient at less cost than at present and in more abundant measure.

According to unverified evidence reported to the Survey by social workers, about 50 per cent. of the families in Canada live on an anual income of approximately $2,000 or less. After meeting the costs of living, it is obvious that, on the above basis, over 50 per cent. of Canadian families have practically nothing left for hospital, doctors', nurses' or dental charges.

2. *Compulsory state health insurance under defined income limits for three classes*:

(a) Wage-earners.
(b) Salaried people.
(c) A class enjoying certain financial independence in the sense that they belong to neither of the above classes, such as small merchants, retailers, druggists, butchers, bakers, farmers, etc.

It might be financed by contributions from the following sources:

(a) The insured.
(b) The employer (in the case of salaried people and wage-earners).
(c) The Provincial Government.
(d) The Federal Government (if possible).

3. *Re-organisation and Control of Nursing Services*:

(a) Registration of nurses and assignment of their duties under conditions that take account of personality and adaptability factors as well as of academic and professional qualifications might be made effective.

(b) In addition to a more scientific inspection of training schools, provision might be made for the supervision of the nurse in services with the object of promoting her professional growth.

(c) A system of superannuation for nurses, similar to that now enjoyed by teachers, might be arranged.

(d) Continuous employment for nurses should become feasible in the light of two conditions, viz.: the removal of the economic barrier between the patient and the nurse and dealing with the fact that only about 40 per cent. of the people sufficiently ill to profit from the services of the graduate nurses now engage them.

(e) Control of nursing services might be in the hands of Provincial Councils of Nurses working in co-operation with a Federal Council.

4. *Federal Council of Nursing.*

This might be a creation of the Federal Parliament, if possible, and subject to a Dominion Board of Control on which the Canadian Nurses Association should hold the majority representation. Representatives of the Canadian Medical Association and of leading lay organisations should also be appointed on this board.

It might exercise functions of an advisory, directive, educational, research and integrating nature. Under section 93 of the B.N.A. Act this council, being federal, could scarcely be clothed with powers of a legislative nature; but it would probably serve as the brain, in an advisory sense, of the various provincial councils discussed below. Its headquarters, both from the viewpoint of population and geography, should be as centrally situated as possible. Its activities would be of a much more scientific nature than serving merely as a clearing house for ideas on nursing conditions.

5. *Provincial Councils of Nursing.*

These councils would be created by provincial enactments and would exercise functions, with the advice of the federal council discussed above, chiefly of an executive and administrative as well as educational nature.

Compulsory registration with these councils of all who care for the sick for hire—including attendants, visiting home helpers, practical women, as well as trained nurses—should be adopted.

The prime function of provincial councils would be to organise and supervise the work of private duty nurses and various types of attendants who care for the sick for hire. Private duty nurses, working directly through local or district registries as part of the provincial organisation, could be given continuous employ-

ment on a regular salary basis. These district registries would serve as branches of the provincial council, working under the direction and supervision of the latter, and bringing the types of nursing services required to the home of patients. The adequate placement of these services would be largely conditioned by the studies of local nursing needs made by provincial councils and by the establishment of effective contacts with the medical profession, training schools, hospitals, departments of health, and with other agencies concerned with the care of the sick.

The question arises as to whether all private duty nurses should be obliged to work under the direction of the Provincial Council of Nurses, and, if so, would there be sufficient employment to keep all those nurses continuously engaged. The following aspects should be emphasized:

(a) Nurses who prefer to remain "free-lancers" would be permitted to do so, but patients of the insured class obviously would not engage free-lance nurses.

(b) Medical evidence, confirmed by the laity, shows that the majority of patients in Canada generally, who need the services of the trained nurse, are now unable to engage these services. It is probable that under a plan of social health insurance all the trained private duty nurses now available could, under an adequately organised and controlled system, be given employment of a reasonably continuous nature.

(c) The Provincial Council and nursing registries should supply a scientific nursing supervision as a reasonable assurance of efficient nursing services.

(d) A Provincial Board of Nursing Control, the creation of the Provincial Legislature, should be established to advise and control the Provincial Nursing Council. This board should be free from political intervention and should be as autonomous as a University Board of Governors. As the problems to be dealt with are primarily those of the nurse, her profession should hold the majority representation on this board. The nurse members might be appointed for a term of years by the Provincial Nurses Association. The Provincial Government, the Provincial Medical Association, and the laity should also be represented on this board.

(e) The chief duties of the board would be administrative, including the appointment of the Provincial Director and other necessary officials, such as the inspector of training schools, supervisors and district registrars.

6. *District Registries.*

These registries would be under the supervision of the Provincial Council of Nursing and would supply the nursing contacts with various classes of the community. Various types of nursing services should be made available, such as: visiting nursing, hourly nursing, daily nursing, special services such as surgical, maternity, pædiatric, and so forth.

Registries should be established in the less populous areas—especially those outside of, as well as within, rural municipalities—and the services of nurses made available under controlled and supervised conditions, to the rural population.

7. *Finance.*

The chief sources of revenue of financing a socialised nursing service may be found in the following:

(a) State health insurance.

(b) Federal assistance.

(c) Fees (nominal fees to insured patients).

(d) Hospital tax on meals costing $1.00 and more.

(e) Tax on luxuries, especially on liquor.

Hard Times

Everyone knows that for two years we have been having "hard times," not only in Canada but all over the world. Our readers have no doubt heard many explanations of why this is so. Mr. Richard Whitney, President of the New York Stock Exchange, in an address to the Merchants' Association in September last, said that in order to reach an understanding of the present depression it is necessary to go back to a well-known law of economics—the law of supply and demand.

According to the law of supply and demand, prices represent the relationship between the available supply of any commodity and the demand for it. When the supply is greater than the demand, prices fall. On the other hand, when demand is greater than supply, prices rise. Since both supply and demand frequently change, the relationship between them is bound to change, too, and for this reason prices go up and down.

Prices, therefore, have a corrective influence in business. When prices rise, producers are naturally stimulated to increase the supply, but meanwhile demand is curtailed because the consumer's money will purchase less. On the other hand, when prices fall, the producer's profits dwindle and cause him to lessen his production, but at the same time the purchaser's dollar will buy more, and thereby, sooner or later, demand is increased. In the long run it is price which tells the producer how much to produce, and the consumer how much he can buy. In this way, prices regulate business.

During the war, the normal law of supply and demand was replaced by abnormal conditions. The countries engaged in the war had to take speedy measures to equip and maintain their armed forces. The demand for some kinds of goods was greatly increased, for other kinds greatly decreased. Prices for certain products were controlled by governments. After the war, the governmental controls in business were removed, and the pent-up forces of supply and demand again exerted themselves, first in a brief boom, and in 1921 in a sharp, world-wide depression.

When prosperity came again after 1921, attempts were made in several countries to prevent future depressions. It was thought that there might be a way of dodging the consequences of this law of supply and demand. In Canada, wheat pools were established to steady the prices of wheat, and experiments in cotton, copper, coffee and rubber were tried in other countries.

The effect of these experiments was to increase the price of the commodity, and this in turn led to increased production. This was very pleasant and agreeable, and for a few years it looked as if this state of affairs would go on indefinitely. But very largely increased production was bound in the end to overbalance the demand, and thus lead to lower prices. The fact that this adjustment was delayed in the prosperous years following 1921, only made the collapse in prices all the greater when it did come.

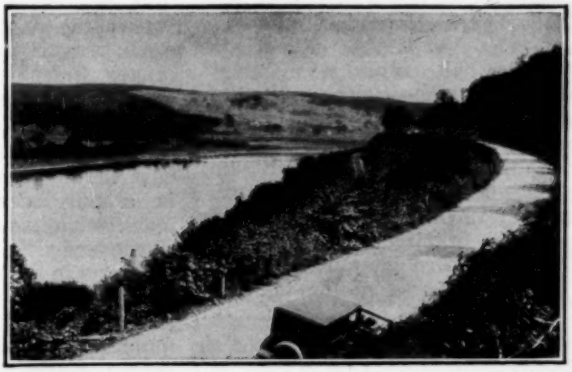
During the same period, there was another kind of interference with the law of supply and demand. This was through rising tariffs and even embargoes. Whether through fear of future wars or through new ideas of national prosperity, nations began to direct their efforts towards producing all or nearly all the things they needed, so as not to have to import commodities from other countries. The effect of this was again to increase and maintain high prices, and so production soared far beyond the demand. It is therefore not astonishing that in the long run a point was finally reached when the volume of production could not find sufficient buyers and in the end prices fell with a crash. Once again, the law of supply and demand took its revenge.

It is misleading to regard the present depression as a disease. It is much nearer the truth to think of it as an ebbing tide. For hours the waters recede, and then when they have reached the farthest point, the ebb tide ceases, equilibrim is re-established and gradually the waters return to the shore.

So, too, it is in business. Before the flood-tide of prosperity can return, invisible under-currents must exhaust themselves. Like the tides, these forces are little subject to human control.

Meanwhile, we may rest assured that the law of supply and demand was not suddenly abolished a few months ago. It is still working vigorously. It has caused a drop in prices and thus hard times, but the same economic forces will bring in more favourable conditions. In fact, it begins to look as if this reaction is already setting in.—J. E. B.

Beach at Point du Chene, New Brunswick



Along the St. John River at Meductic

*The Sequelae of Diphtheria**

By H. B. CUSHING, M.D., Montreal

Of all the acute infectious diseases of childhood, diphtheria is the one concerning which we have the most accurate knowledge. Not only are we thoroughly familiar with the cause, symptoms and course of the disease, but we have at our command efficient methods for diagnosing the disease, curing it, preventing it, and, in short, for absolutely eradicating it in any civilised country. In other words, diphtheria has no license for existing or for having a death rate. In spite of all this, diphtheria is still one of the chief causes of death among young children and is the third most important cause of death in children under five years of age in this country: only diarrhœa and pneumonia are more common. This being so, one may be excused for spending a little time inquiring into the cause of these deaths and be sure of discussing a subject of importance to everyone.

Children with diphtheria die from two causes, broadly speaking. They either suffocate from membrane in the larynx or lungs, or they die from the effects caused by diphtheria toxin on the organs of the body. I wish to speak only of the effects caused by diphtheria toxin. Diphtheria is a local disease: toxin is produced at the site of the lesion, usually in the throat, absorbed, and acts on the various organs. It is a slow poison, taking some weeks to produce all its effects. The dose of the poison any given case has received when it first comes under observation can be approximately estimated by the extent of the local lesion and its duration before the antitoxin is administered. An adequate dose of antitoxin prevents any further damage, neutralises any toxin in circulation, or which may be produced later, but is of no avail in counteracting the toxin already absorbed and fixed in the tissues.

There is a prevalent impression that the action of the toxin is most uncertain, causing heart failure in one patient, nephritis in a second, bizarre forms of paralysis in a third, and so on without any definite rule or reason. This is not so: if one observes carefully a large series of cases one finds it possible to estimate, as I have indicated, the approximate dose of toxin received and to prophesy more accurately than in most diseases the subsequent course of events. The action of the toxin is surprisingly uniform, and although naturally one individual differs from another in his resistance and reaction, still the after-effects of a severe attack of diphtheria are remarkably similar in all cases.

Let us consider these effects more in detail. For clinical purposes, diphtheria affects three organs only, the kidneys, the heart and the nervous system. It may affect others, presumably does so. In fact, from autopsy findings and animal experiments, it probably affects the thyroid, liver, pancreas, and especially the suprarenals. But so far as our present means of observation go, we have no facilities for accurately estimating the damage to these organs, and the effects on them apparently do not influence the clinical picture. Let us confine ourselves then to the three organs which give obvious clinical signs or symptoms.

The first evidence of the effect of the diphtheria toxin is from the kidneys in the form of nephritis. This is a pure degenerative nephritis, manifesting itself at the end of a week or earlier by the presence of albumin and casts in the urine, usually in considerable quantity. This nephritis is almost constant after diphtheria, quite constant in all severe or late cases, causes diminution in the

(*Reprinted from International Clinics, Vol. I and II, Series 36. Published by permission of the J. B. Lippincott Company.)

amount of urine passed, but never dropsy or uræmia or even serious retention of nitrogen or chlorides in the blood. True inflammatory nephritis after diphtheria, with general œdema or uræmic symptoms, means either an error in diagnosis or a mixed infection and is not due to the diphtheria toxin. The form of nephritis which one sees almost constantly after diphtheria is purely toxic, with degeneration and desquamation of the epithelial cells lining the tubules. It does not cause marked symptoms and always disappears entirely in a few weeks, leaving no after effects. In many thousand cases observed in the Alexandra Hospital, Montreal, over a term of years, I can recall only a very few leaving the hospital with any signs of nephritis, and in all these there was reason to believe that nephritis was present before the diphtheria or was due to some other cause than the diphtheria alone. If the nephritis is so benign and transitory, is it of any clinical significance? Apart from influencing our treatment as regards diet during the first three weeks, I firmly believe it is of little importance beyond being a practical indicator of the amount of intoxication, and hence of what may be expected from the other organs.

One wishes devoutly that the same could be said of the next organ to be involved, almost simultaneously with the kidneys, and that is the heart, the commonest cause of death in the fatal cases of diphtheria. Cardiac failure after diphtheria has always attracted much clinical interest, and varied have been the opinions as to its cause. Thrombosis, paralysis and vasomotor failures have all been blamed, and it is only since the work of Warthin and others in this country within recent years that the condition has been placed on a sound pathologic basis. We know now that the post-diphtheritic cardiac symptoms are due to an acute degenerative myocarditis. It is a toxic parenchymatous degeneration or necrosis of the muscle fibres of the heart, with a later reparative inflammatory process with regeneration of the muscle. Both the contractile and conducting mechanisms of the heart may be affected by these processes. The occurrence of this myocarditis is apparently as constant as the nephritis, though it is harder to demonstrate. Only through change in the colour of the patient and the character of the pulse does one suspect its presence in mild cases. Blood pressure records help little, nor does the electrograph until the condition is well established. Cardiac dilatation with vomiting, heart-block or sudden death terminates the picture in the worst cases. The symptoms of myocarditis show themselves first on the fifth to the seventh day, culminate on the tenth to the fourteenth day, and rapidly subside, although it is several weeks before the heart returns to normal. Still, if the twenty-first day is passed, one should no longer fear absolute cardiac breakdown, if reasonable precautions are taken. It is of great interest to know what becomes of those severely affected hearts later. Are they permanently crippled, does the degenerative myocarditis lead to a fibrosis later in life? I can only say that I have been interested in following a number of the worst of these cases, which unexpectedly survived after being pulseless and with signs of cardiac dilatation, and in no single case was I able to demonstrate after one year that there was any disability whatsoever remaining, either by functional tests, physical examination or electrocardiographs. It is my firm belief that once the patient survives the acute attack there is absolute restoration of the heart to normal. I must confess that I am speaking only of children, and that it is possible that in adults the reparative power of the tissue may not be so great.

If, then, the outlook is so bright if the critical two weeks are survived, are there any therapeutic means of assisting the patient through this period? The only adjuvant I have any faith in is absolute physical rest,

in whatever way it may be secured. The patient should not be permitted to raise an arm from the bed; if vomiting begins, all nourishment by mouth should be stopped for two or three days. Morphine is given if there is any restlessness, though this rarely occurs until the case is beyond hope, but rather a lassitude and somnolence. Digitalis does harm by increasing the tendency to vomiting and heart-block, and other so-called "cardiac" stimulants seem of little avail. Remember always that it is only a few days to be survived and then the natural processes of repair will affect a cure.

The third clinical manifestation of the toxin, the effect on the nervous system, is always fascinating to watch. Until Walshe in England gave us the clue to these curious paralyses they seemed utterly irregular, purposeless and fantastic. Walshe showed clearly how the first effects on the nervous system were local, the toxin apparently passing along the local nerves from the site of the lesion to the central nervous system, affecting first the local nerves, then the neighbouring nuclei, and then the general nervous system as a whole. So in the ordinary pharyngeal cases of diphtheria there is first a paralysis of the soft palate, then two or three weeks later of the eyes and almost immediately after a weakness of all the body muscles, with loss of tendon reflexes. If the diphtheria occurred in a wound of the leg, there would be paralysis of the leg first. So constant is this sequence that I have more than once observed in cases of diphtheria of one tonsil only, that there was paralysis only of that half of the palate. The local paralysis is seen usually in the third week if closely looked for. The general paralysis begins about two weeks later with general weakness, paralysis of accommodation, squint, sensory disturbances and loss of reflexes. It culminates almost invariably at the end of six weeks, and then rapidly and steadily improves. The prognosis as regards life depends entirely on the involvement of the diaphragm and muscles of respiration. Fortunately, these muscles are the last involved and their paresis is short lived. If one can keep the patient alive for a week, all symptoms will subside, for in this, as in all other toxic sequelæ of diphtheria, recovery is absolute and complete in the process of time.

In a typical case of diphtheria treated late with serum one observes the immediate improvement and subsidence of all the evidences of the disease, so that the patient appears convalescent. Then the quickly developing evidence of the later action of the toxin; the appearance of albumin, rapidly increasing in amount and later disappearing entirely; the progressive impairment of the heart, culminating in ten days, when the patient hovers between life and death for a few days, with subnormal temperature and almost imperceptible pulse; lastly, the paralysis beginning locally at the end of three weeks, becoming generalised in two weeks more, so that the patient passes through another critical period at the end of the sixth week, and barely survives a threatened respiratory paralysis, and finally recovers entirely, with apparent restoration to normal. These observations can be made in hundreds of cases, differing only in the degree of the various symptoms caused by the toxæmia, for, as stated previously, one of the most striking things about the effects of diphtheria is the uniformity of the symptoms caused by the action of the toxin.

If this progressive clinical observation is a true one, what practical lesson may be drawn from it? First and foremost, the importance of early treatment, of an adequate dose of antitoxin at the earliest possible moment, by a route through which it has the most rapid action, i.e., intravenously in all cases in which one has reason to suspect a dangerous dose of the toxin to have been absorbed.

Secondly, the need of close observation of the patient, noting first the albuminuria giving a rough measure of the intoxication; next, the evidences of involvement of the heart muscle, and, lastly, the progressive involvement of the nervous system. The final lesson is the hope of the absolute restoration of the body to normal if the two brief critical periods can be survived; the one at the end of two weeks from cardiac failure and the other at the end of six weeks from respiratory paralysis.

Childhood and Tuberculosis

The last new thing in the realm of tuberculosis I will mention, and most important of all, is—children. The charm of children is their "surprisingness." In the past few years there is a new light on tuberculosis in children, thanks to such men as McPhedran. We have long been hunting and hunting among adults for the early lesions and early stages of tuberculosis and have notoriously failed to find them. It is strange we have been so slow to see that some, at any rate, of the early lesions in an infected household would be most likely to be among the children, whose contacts are the closest contacts, and whose soil is virgin soil. Our ideas about children lagged a generation behind our knowledge about adults, chiefly because we had a single standard for measuring alike disease in the adult and the child. But the two types are almost two diseases, so different that they have little more than the causal organism in common. To use the terminology of syphilis, the *primary lesions* of tuberculosis are usually found in children, the secondary and tertiary usually found in adults. The very beginnings of tuberculosis are found commonly in children and more seldom in adults, and the more advanced stages are found commonly in adults and seldom in children. Diagnosis, treatment and prognosis all differ as between the young and the older. In the adult there are usually symptoms; in the child usually none, or slight, late and difficult to estimate. No single symptom is pathognomonic. Cough is as often absent as present. A plump appearance does not rule out disease, nor does emaciation prove it. The stethoscope has little value. "By physical examination alone the most skilful examiner *cannot make a positive diagnosis* of tuberculosis in children; neither can he exclude it as a possibility—no matter what the appearance of the child." (Chadwick).

The great *new light* of childhood tuberculosis is shed by the x-ray. Skilfully made films, carefully and thoughtfully interpreted, help more than all other means together to an understanding of the diagnosis, the course and the prognosis of the childhood phase. Plates in two planes are often needed, the postero-anterior and oblique. Now that we know better what the tuberculosis of childhood is our ideas of prognosis have changed. It is true that the adult type of tuberculosis in a child has a very bad outlook, but *childhood tuberculosis* in a child may have a very good outlook.

The discovery of the child in tuberculosis opens up a great new continent for exploration. It is in this new continent of childhood that the most fruitful explorations of the anti-tuberculosis forces will be made during the next generation. These sunrise people of a new day are always new, always fresh, always invite our quests, always more than repay what we can do for them. What we wish to do for the race must be done for the child. On their behalf we must even learn a good part of our tuberculosis all over again.

From What Is New in Tuberculosis, Dr. D. A. Stewart, C.M.A. Jn., January, 1932.)

Vacation Possibilities in New Brunswick

(Canadian Nurses Association General Meeting, Saint John, June 21-25, 1932)

New Brunswick can offer the visitor almost any type of vacation that is to be had, but it is generally assumed that when people come to the Maritimes for a holiday they wish to spend most of the time near the sea. Some, of course, may find pleasure on the inland lakes and streams and in the depths of the forest; others will want the "Country Club" life, with golf, tennis and the atmosphere of the big summer hotels. All of which is available in province.

For those who expect to attend the biennial meeting in Saint John in June, the following may be of help in arranging for a vacation visit in the province. No attempt is made to describe the numerous opportunities for delightful motor trips, but, rather, attention has been confined to the places where one may expect to stay for as long or short a time as is desired —and rest or play as the spirit so moves one.

Taking Saint John City as the starting point, and supposing vacation will not be counted on until after the meeting, we will work out the three directions, west, north, and east consecutively—south will take one across the Bay of Fundy to Nova Scotia, another province of limitless vacation prospects.

It is well for the visitor to the Maritimes to remember the historical importance of this section of our Dominion. The three maritimes and Quebec have bound up in their soil the earliest history of the country. Though there are no turreted castle ruins or magnificent cathedrals to mark the trend of time as in the older countries of Europe, yet there are stores of historic wealth with which we should be familiar and which should have a decided fascination for any Canadian. Tangible evidence does not always remain, because early buildings and forts were built of wood and most of them have long since returned to dust. However, one can find considerable evidence in some places of the life that was carried on three hundred years ago, but best of all the beauty of the country is as unspoiled as when it first intrigued the gaze of the great explorers, Cartier, De Monts, and Champlain. New Brunswick is justly called "Canada's unspoiled province".

Starting in a south-westerly direction along the Bay of Fundy coast towards the State of Maine are several places where a delightful seaside vacation may be had. The road is excellent, and one may travel, if one's own car is left behind, by bus, although the bus will not take one off the main trunk road into several of the quaint little fishing villages, chiefly Lorneville, Dipper Harbour, and Mace's Bay, reminding one of the old world coast of Scotland or France.

At New River Beach, about 20 miles from Saint John, you will find one of the finest stretches of white sandy seashore on the north Atlantic coast, and here you may hire a log cabin or a house nestling against a background of pines and firs, and facing the wide sweeping waters of the Bay of Fundy. You can watch the magic of old Fundy's tide twice a day, bathe in the stinging salt water (they say it "steps up" metabolism), have bonfires on the beach, and if the moon and tide are high at the same time, the sheer stark beauty of it will quite take your breath. You will be left with a picture of sky, water, rock, sand, and trees so blended that you will never forget it. Perhaps some old "four-master," with sails all set, all gold, under a brilliant moon, will appear out of the horizon, a rare sight in these days, to add one more perfect touch to the picture. There are two log cabins accommodating five persons each, and one house for six, and all you need is your food. There are fireplaces for the days when Fundy's fog will make you seek inside warmth. There is also a Tea Room where meals may be

had. The cabins can be rented for any length of time.

For those who do not want a seashore holiday, on this same route, fifty miles from Saint John, is a charming fresh water lake, Lake Utopia. Here there are inviting stretches of sandy beach, bathing, canoeing, boating and fishing. Camps may be rented, and if desired, meals had at a central dining room or prepared in camp. This takes one off the beaten track into a section of exquisite inland scenery.

Continuing on this same route, we pass through the village of St. George and on to St. Andrews-by-the-Sea. This is the popular summer resort made famous by the C.P.R. Hotel Algonquin and the many magnificent homes of the wealthy summer residents. Golf, tennis, bathing and boating may be had here. The scenery of the island-dotted Passamaquoddy Bay presents an ever-changing picture, and you will want to visit Deer Island and Campobello Island. St. Andrews itself is a delightful old Loyalist town. There are many things of historic interest to see: the old Block House, the Greenwich Kirk, and the quaint old houses of soft, low, beautiful lines, such as marked the simple taste of our Loyalist forefathers..

The fishing weirs that dot the coast line all about the Bay are always of interest to the "land lubber": these are used to catch sardines, the chief industry of this section of the province, and the largest sardine-canning factory in the world is at Black's Harbour, a little further up the Bay.

Following this same route we come to the St. Croix River, marking the boundary between Maine and New Brunswick. This river has a point of considerable historical interest. Watch out for the little island with the lighthouse and you will see what is now called Docket's Island, the very one where Champlain in 1504 and 1505 spent his first winter in Canada, and where he lost 35 of his 79 men from scurvy. In the 18th century the skeletons of those buried on the island became exposed by the erosion of the sea and the spot became "Bones Island". Coming to St. Stephen we find the International Bridge, and across the river the United States town of Calais.

There is always a fascination to living on an island, especially an island in the sea, and if you would like to have this experience, Grand Manan, situated at the mouth of the Bay of Fundy, nine miles from the United States coast, can offer all the thrills that your imagination built around your first geography lesson on islands. This is a favourite vacation resort, offering natural scenic beauty and a strong, healthy climate with freedom from hay fever. There are many points of geological interest in the peculiar rock formation of this island. It is twenty-one miles long and nine miles wide. Boating, bathing and fishing provide plenty of holiday entertainment. To get to Grand Manan one takes a motor ship from Saint John and is able to enjoy a refreshing salt water sail of several hours either direct or through the beautiful Passamaquoddy Bay region, depending on the day of sailing. Several small lakes on the island will give you a chance to try your luck for speckled trout. Hotel and private home accommodation may be had.

The next route we will follow is along the Saint John River, going in a northerly direction to the centre of the province. This river is the largest between the St. Lawrence and the Mississippi, and is popularly known as the "Rhine of America"—not because it actually resembles the Rhine, with its peaks and bluffs topped by old robber baron castles, and its steep, grapevine-covered slopes, but because it is equally as beautiful in a very different way. Here you will find inland scenery unsurpassed—soft, rolling hills on which are prosperous farms, stretches of sandy beach such as one rarely finds inland, tributary lakes and rivers, each one a gem in itself, luscious grassy intervales and small wooded islands. One can really

only know the river by travelling in canoe with a tent for a house.

The world-famous Reversing Falls at the mouth of the river attract thousands of tourists each year. Putting aside the explanation in the forces of nature which produce this phenomena, here is the Indian legend of the formation of the Falls: Glooscap, one of the Indian gods, had control of the animals as well as the Indians. Big Beaver was not behaving in the Passamaquoddy district, and Glooscap went after him. Big Beaver fled and built a huge dam across the mouth of the river flooding the whole country back of it and making a huge lake. When Glooscap saw the dam he smote it with his mighty club. A piece floated out and became Partridge Island at the entrance of the harbour, and the split rock below the Falls is Glooscap's club, which he threw away after smashing the dam. The big lake disappeared, leaving only what is now Grand Lake, the largest lake in the province.

The best way to see the Saint John River is to take the steamer at Saint John and enjoy a day's trip to Fredericton, where the steamship line ends. If you have a car, the river road to Fredericton makes a magnificent motor trip, and lunch can be had at one of several places en route. Steamers also run to the head of the two largest lakes, Washademoak and Grand Lake, which is 30 miles long. Hotel accommodation can be had at the head of these lakes.

A week-end in Fredericton, the capital of New Brunswick, will well repay one. There is much of interest here. This small, tree-shaded city, with its perfect little cathedral, parliament buildings, University of New Brunswick, Normal School, Old Government House, fine homes and beautiful gardens, has a decided charm of its own.

Following further up the river one must travel by train or car. At Perth very comfortable log cabins with every convenience may be had, and one may stay as long as good food, the rushing river (it is much narrower here, with a swifter current), the green hills, and the sounds that go with farming in June, hold you.

At this point on the river, if you have a car and you wish to lose yourself completely to the world, arrangements can be made for accommodation near the head waters of the Tobique River, one of the most famous salmon-fishing rivers on the continent. It is a fascinating motor trip along the Tobique from Perth to Riley Brook, where you are 30 miles from the nearest railway point.

Going back to Fredericton again, instead of continuing up the Saint John River, we cut diagonally across the centre of the province in a north-easterly direction, following first the lovely Nashwaak River, and then meeting the head waters of the Miramichi at Boiestown. Here you are in the heart of the big game country: comfortable camps may be had here, with central dining-room service, and you may go salmon-fishing if your purse and muscle will permit indulging in the "King of Sports". The route along the Miramichi is through densely wooded country, weaving back and forth across the river, and running for miles through stretches of unsettled forest, then coming out at small villages in sight of the river, until finally you smell the bracing salt sea again, and you have come out on the east coast and the Gulf of St. Lawrence.

At Newcastle you may take two ways of getting to the Bay Chaleur. One way is to follow along the coast until you come to Caraquet, where good accommodation is to be had and where you can enjoy a complete rest watching the fishing fleets come and go, and the life of the quaint little French fishing village. The other way is straight north through the maple and birch woods to Bathurst on the glistening Bay Chaleur. There is not a more beautiful and entrancing stretch of water in the world. The many-coloured hills of Quebec, the continually-changing sky line, and the

magnificent sunsets create a panorama of which one never wearies. It was Jacques Cartier, sailing into the Bay in 1534, after coming through the icy blasts of the Gulf of St. Lawrence, who gave it its charming name. Looking on its peaceful beauty one can hardly believe that near Campbellton the hills once echoed and re-echoed with the last naval battle of the Seven Years' War in America.

At Youghall Beach, a short distance from Bathurst, is another of those flawless stretches of seashore which seem to have been made to lure many from the workaday world and tempt them to lounge forever on the dry, white sand and listen to the hypnotic pounding of the surf. Add to that, sea water of extraordinary high temperature, and you have a combination of nature's gifts hard to equal. Accommodation may be had at two farm houses only, as the camps and houses are otherwise all privately owned.

There are many attractive villages on this coast on the way from Bathurst to Campbellton at the head of the Bay, and a few of these cater to vacationists. One especially popular place is Jacquet River, and this year accommodation may be had at Petit Rocher also. There is excellent bathing all along the bay. When Lord Byng was travelling through this section of the country, he had his train stopped for two days at New Mills because the scenery of the Bay so captivated him.

Before coming to Dalhousie, a little town built on the face of a steep hill, and now the site of one of the biggest pulp mills in the country, one should stop and inspect the beach at Fossil Cove. Here can be found fossil corals, sponges, etc., showing that a warm sea existed here thousands of years ago.

The Bay now suddenly narrows, and at Campbellton, nestling among high blue hills that remind one so of Scotland, one comes to the mouth of the Matapedia River. Fifteen miles farther up this magnificent river, where the Restigouche River coming down from the depths of the virgin forest meets it, you say au revoir to New Brunswick and bon jour to Quebec. (This is the route out of New Brunswick for the Gaspe coast.)

The third and easterly route out of Saint John takes you through the Kennebecasis River valley and into one of the most fertile sections of the province, with splendid farms on all sides, some of them dating back to the time of the Loyalists. Coming to Moncton one finds a busy railway junction city, and it is from here if you are travelling by train or car that you will start on the road to Prince Edward Island, or Nova Scotia. You will want to see the tidal bore on the Petitcodiac River, at the head of the Bay of Fundy.

On the Straits of Northumberland, about fifteen miles from Moncton, are some famous beaches at Point du Chene. Excellent hotel accommodation can be had at Shediac, about two miles from the best of the bathing beaches. Conveyances to and from the beaches can readily be obtained at the hotel.

The short neck of land which joins New Brunswick and Nova Scotia, the Isthmus of Chignecto, is especially interesting because it was one of the earliest French settled sections of old Acadie. In the struggle between France and England to gain possession of the country forts were built by both sides, and today the remains of old Fort Beausejour (later Fort Cumberland) are well worth inspection.

And so, if you wish, you will continue your journey from here to the "Island" or to Nova Scotia, but the New Brunswick Registered Nurses Association hopes that you will spend most of your vacation here in this province, and offers you the warmth of a real "down-east welcome," and is glad to answer any enquiries or make arrangements for those attending the Biennial. at any time.

Kindly communicate with Miss H. Dykeman, Chairman Transportation Committee, Health Centre, Saint John, New Brunswick.

ACCOMMODATION AT VACATION SITES IN NEW BRUNSWICK

(This does not include hotels in towns and villages en route.)

BAY OF FUNDY DISTRICT

NEW RIVER BEACH: Cabins	2 cabins for 5, $30 a week.
Miss Nora Knight, Rothesay Collegiate School, Rothesay, N.B.	1 house for 6, $35 a week.
LAKE UTOPIA: Bryn Derwyn Camp	Main camps, room and board, $4 a day.
Jas. W. Brine, St. George, N.B.	Other camps for 5-7 people, $5 to $6 a day.
ST. ANDREWS-BY-THE-SEA:	
Algonquin Hotel	Single rooms with bath, $11 to $16 a day. Double rooms with bath, $10 to $11 a day. Single rooms without bath, $10 to $12 a day. Double rooms without bath, $9 to $10 a day.
Kennedy House	$4 a day and up; $28 to $35 a week.
Seaside Inn	$3.50 a day; $15 a week on third floor. $18 to $21 a week on second floor.
GRAND MANAN:	
Rose Cottage	$2.50 a day; $10 to $18 a week.
Swallow Tail Inn	$3.00 a day; $13 to $15 a week.

SAINT JOHN RIVER DISTRICT

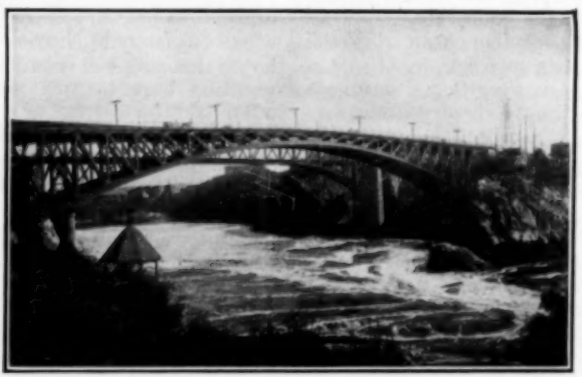
WOODMAN'S POINT: Miss Inches	$15 a week (20 miles from Saint John).
MORRISDALE: Mrs. F. K. Reynolds, 20 Millidge Ave., Saint John, N.B.	Camps with central dining room, $1 to $1.50 a day—Meals a la carte.
GRAND LAKE: Chipman—Chipman House	$3 a day; $15 a week.
WASHADEMOAK LAKE: White House Inn	$3 a day; $15 a week.
FREDERICTON:	
Queen Hotel	$4 to $5 a day (American Plan).
Barker House	$4 to $4.50 a day (American Plan).
Windsor Hotel	$3 to $3.50 a day (American Plan).
PERTH: Ann's Tea Room, c.o A. A. McLaughlin, Perth, N.B.	Room in cabins or main house, with meals, $3.50 a day.

MIRAMICHI DISTRICT

BOIESTOWN ON THE MIRAMICHI: The Griffin House, Wm. F. Griffin, Boiestown, N.B.	$2.50 a day (cabin and central lounge and dining room, including meals).

BAY CHALEUR DISTRICT

CARAQUET: Sea Gull Inn, Miss Josephine Rive	$2.50 a day; $14 a week.
YOUGHALL BEACH:	
Miss Armstrong	$13 a week.
Mrs. Kerr	$12 a week.
BATHURST:	
Carleton Hotel	$3 and $3.50 a day; $12 and $15 a week.
Gloucester Hotel	$4 and $4.50 a day.
PETIT ROCHER:	
Miss G. Louise Burns, Bathurst, N.B.	Accommodation for 6 persons, $3 a day; $15 a week.
JACQUET RIVER: The Bay View Inn, Paul Doyle, Esq., Jacquet River, N.B.	$18 to $20 a week.



Reversing Falls, Saint John, N.B.

Admiral Beatty Hotel, Saint John, N.B.

The Admiral Beatty Hotel will be headquarters for the Sixteenth General Meeting of the Canadian Nurses Association. The management has placed at the convenience of the Association Floor 11 of the Hotel; this arrangement provides accommodation for general sessions in the well-appointed ballroom, for section sessions and committee meetings in smaller rooms, for the exhibits, both professional and commercial, as well as registration and information desks, all on the same floor. It is hoped that all delegates and visiting nurses will find it convenient to be guests at the Hotel during convention week, where they will be assured excellent service from the hotel staff.

Reservations for accommodation should be made early. The hotel rates per day are: Single room without bath, $3.00; Double room without bath, $5.00; Single room with bath, $4.00, $4.50 and $5.00; Double room with bath, $6.00, $7.00, $8.00 and $9.00 Additional persons in room, separate bed, add $2.00. All rooms have hot and cold water and toilets.

Nurses are advised to state when making reservation that they are members of the Canadian Nurses Association.

Reservation should be made to Mr. E. B. Sweeney, Manager, Admiral Beatty Hotel, Saint John, N.B.

The Anglo-Yugoslav Children's Hospital

By FRANK YEIGH, Toronto

Few people probably realise the radiation of nursing services, especially during a war. A striking example is afforded by the Anglo-Yugoslav Children's Hospital, in Belgrade, the capital of that country of over ten million people.

It is a stirring tale of a carrying-on policy on the part of some of the nurses who served in the Serbia of pre-war days, and especially during the Serbian retreat of mid-winter, amid scenes that, although now largely forgotten, yet remain among the most terrible of all. Many Canadian nurses served in this wonderful war service and, naturally, returned to Canada after the Armistice. A few remained, however, not only from Canada, but from the British Isles, notably Dr. Katherine S. Macphail, a graduate of a Scottish University, who, realising the continued need for nursing service for the children, started largely on faith a hospital in Belgrade. From the start it was assisted by the noble Save-the-Children Fund as one of its benefactions on behalf of needy women and children in a score of countries, regardless as to whether they were allied or enemy.

Today there stands a striking building in the heart of Belgrade as the only exclusively children's hospital in that country, and the fame of which has gone far afield, so that it is frequently visited by medical deputations from other European countries. Starting in 1919 with poor equipment and accommodation and with only a handful of little patients and an assisting nurse or two, over a hundred thousand children have passed through its books, either as out or in-patients. What it has meant to the suffering little ones of that land cannot be recorded or realised. The broken-down barrack-hospital of twelve years ago is now better housed and is largely supported by the Serbian Government, although a further five thousand dollars is needed from voluntary offerings to carry on its work efficiently. The administration is still in the hands of Dr. Macphail, in close co-operation with the National Ministry of Health, and the Queen is an active supporter.

The writer visited the hospital and was thrilled with the work being done. Every one of the sixty cots was occupied by relatively happy patients drawn from all parts of the country, and under the care of a well-trained staff, mostly Serbian. He will not soon forget, however, the scenes at the out-patients' quarters, where early in the morning peasants came in large numbers, sometimes from long distances and on foot or on pony back with their sick charges, forming a most helpless and hopeless looking gathering of humans, in striking contrast with the cared-for ones in the adjoining wards. The gratitude of the parents was touching in the extreme, and one felt proud that here in this comparatively distant and partially unknown land, the kindly beneficence of friends far away and the unselfish service of a Scotch lady doctor were transforming lives by the hundreds, indeed the thousands.

Provincial Nurses' Associations in Canada have from time to time had a share in this splendid welfare work by making small grants, and if any others, as associations or individual members thereof, would like to share it, the Save-the-Children Fund, through its Canadian Committee, will be glad to act as almoners, of which the writer is the Canadian representative, at 588 Huron Street, Toronto.

Institute of Public Health
Faculty of Public Health of the
University of Western Ontario
LONDON CANADA

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
Miss MILDRED REID, 10 Elenora Apts., Winnipeg, Man.

Methods of Teaching Chemistry

By NORENA S. MACKENZIE, Assistant Instructor, School of Nursing,
Montreal General Hospital, Montreal

Nursing is an art which receives its dicta from science, hence science subjects have been included in nursing curricula. Parallel with the evolution of medicine has come a nursing service, which daily grows more detailed; and the rapidity with which metabolism research has grown, and the therapeutic use of biological products, has increased the number of teaching hours in schools of nursing.

The teaching of chemistry in schools of nursing is not simply to add to the number of teaching hours, nor an attempt to teach student nurses much about chemistry itself in a comparatively short space of time. It is included in the curriculum to emphasize and, if possible, to cultivate an appreciation of the necessity for accuracy in observation and description, and to assist in the explanation of subjects of which it is the basis.

If chemistry has not been included in the educational programme of students anticipating entrance to a school of nursing, they would be prone to find a short, intensive course confusing and almost beyond their comprehension in detail, if it were not taught by one whose thorough knowledge of the subject permits of great simplicity in teaching and a fine appreciation of its relationship to other subjects in their course.

It is the duty of a school to give its students a balanced course of study. The position a subject holds in any curriculum depends upon its contribution to the ultimate object of that form of education, and as the ultimate object of a nursing curriculum is to graduate nurses who will render intelligent care to their patients, chemistry, among other sciences, has been included in the course of study in order that the nurse may have a greater comprehension of the value of such subjects as dietetics, materia medica, metabolism, bacteriology, physiology, and urinalysis.

The teaching of chemistry produces problems in many schools. Frequently the greatest difficulty is that the nurse-instructor is not qualified to teach the subject and often there is no properly equipped laboratory, or at best a poor makeshift. In the event of the former, there are many sources within the hospital from which co-operation may be obtained, viz.: the dietetic department, the dispensary, and interne, or perhaps if especially favoured as we, one of the staff of the metabolism department may agree to teach the course. It is preferable that the instruction comes from one within the hospital, because he has a finer sense of the application of chemistry to nursing. However, if that be impossible, the instruction may have to be obtained from local high or technical schools. Many hospitals, if favourably situated, send their students to the university for chemistry, where they receive a splendid course from professors who appreciate their needs.

The number of hours available for teaching chemistry is invariably a

difficulty. In the school for nursing in this hospital, as well as many others, thirty hours have been allotted to this subject, consisting of ten hours of lectures, each followed by a two-hour laboratory period. Fortunate are they whose teaching unit includes a science laboratory, because then there is no problem of fitting in the period most suitable for the student nurse which will not encroach upon the time of the students or internes whose laboratory is being used, as is often the case when a hospital laboratory is the only one available. If the student nurse is sent to the university for chemistry the difficulty is solved, but it still remains a problem for the school which has no access to a university nor a hospital laboratory. In that event it may be possible to obtain the use of the high school equipment. From whatever source the equipment may come, it is essential that the student perform her own experiments. If she be a spectator only her interest lags, and certainly it is not conducive to acute observation, nor is she likely to attempt to formulate any conclusions of her own.

A thorough preparation for the course involves a careful outline of each lecture and laboratory period. It has been found very beneficial in this school to give each student a printed detailed outline of each laboratory period, because, first, those to whom the subject is new will follow more accurately; second, it eliminates the waste of time in dictating the procedure and the possibility of inaccurate copying by the student; and, third, it forms a compact synopsis of the entire laboratory work for future reference. Devoting a short time at the end of each laboratory period to summarising what has been done and pointing out its relationship to other subjects will give the student a clearer vision of its purpose. In order that the laboratory supervisor maintain a definite correlation between the lecture and the experiments, she should attend the lectures with the students; and if there be a large number in the class to whom chemistry is a new subject, it is unwise to attempt supervising too numerous a group.

Most schools prescribe a text for supplementary reading. There are many good books on chemistry for nurses, among them:

Principles of Chemistry and Their Application (Bartlett & Ink, 1927).
Outline of Chemistry: Sister Domitilla (1930), which is a student's work book as well.
Essentials of Chemistry: Luros (1929).
Applied Chemistry for Nurses: Goostray-Karr.
Fundamentals of Chemistry: Bogert (2nd edition, 1928).
Chemistry for Nurses: Peters (1923).

When the lectures and classes dealing with carbohydrates, fats, and proteins are being studied, the student may be asked to review the physiology of the digestive system, and also be assigned reading in books dealing with dietetics and nutrition.

It seems that no course is complete without an examination. This may be written or practical, or both. But whatever form this takes, its main objective should be ascertaining the students' ability to appreciate those points bearing a direct relationship to nursing.

THE SURVEY REPORT IS PUBLISHED

The Report of the Survey of Nursing in Canada by Dr. George M. Weir is ready for sale. Copies may be obtained through the secretaries of provincial associations, through the National Office, 511 Boyd Building, Winnipeg, or from the University Press, University of Toronto. The price is $2.00 for single copies or $1.75 in groups of ten. The reason that the lower rate can be given in groups of ten is because of a saving in postage. Those who wish to purchase the Report are reminded that provincial associations are desirous of selling as many copies as possible and will appreciate their members applying to the secretary of the provincial organisation to which they belong.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section.
MARY F. CAMPBELL, 344 Gottingen Street, Halifax, N.S.

The Mental Health Clinic

By Dr. S. R. MONTGOMERY, Whitby, Ont.

For a long time we have realised the need and great good that has resulted from the practice of preventive medicine. Our boards of health are well established in all large centres, and more and more we find the smaller communities demanding better facilities for combating and preventing the spread of disease. We have long hoped that these hygiene methods would spread to the mental field, for it is well known that we cannot separate mind from body. So that a year ago, when the province of Ontario established its mental health clinics, we, who are in psychiatry, felt that we were making a great advance in medicine.

May I justify this establishment of mental health clinics. Each year in Ontario there are roughly 2,000 admissions to mental hospitals. Of this number, something over 400 are admitted to the Ontario Hospital at Whitby. These mentally ill persons are in the community an average of one to three years with little or no treatment before admission to hospital. Of our three million population it is estimated that 7,500 are mentally deficient. Our one hospital at Orillia, especially adapted to the care of this latter group, has accommodation for 1,500 persons, and, as well as always being filled to capacity, has a constant waiting list of about 1,100 names.

We all realise the need for good physical health, and even greater is our need for good mental health. Our whole happiness depends upon it. Dr. Hartwell, in his recent book, "Fifty-five Bad Boys," has well summed up when he says, "In the final analysis the behaviour of all human beings, both children and adults, is their attempt to gain happiness. All their behaviour and their mental life is, as far as they are able to control it, a striving toward this end. Unless one understands the child in this desire for happiness one does not understand him at all." How must we gain and maintain this happiness or mental health? By facing squarely all life situations and dealing with them adequately.

For a long time our provincial institutions were considered places of incarceration only. The name "asylum," though originally spoken in a kindly way, for it means place of refuge, took on a harsh sound and was spoken with sadness or jest. Fortunately, we have changed the name to "hospital," for hospital means "place of treatment," and gradually the old prejudice is being broken down and more people are being brought to hospital. Whereas, formerly, mental patients were hidden lest they be placed in asylums for incarceration, now they are being brought to mental hospitals by family and friends for treatment. When one realises that at Whitby 60 per cent. of admissions go home each year, it is readily understood why the general public feeling is changing. This change in feeling no doubt partly accounts for our increased admission to mental hospitals.

With this as a background, may I now enlarge on the clinic, its activi-

(A paper read before the Alumnae of Nicholls Hospital, Peterborough, Ont.)

ties and policies? One clinic group now works out of each Ontario hospital, and is made up of a psychiatrist, a social worker, a psychologist, and a secretary. We attempt to cover our respective hospital areas. Our duties are four-fold:

(1) We do psychiatric follow-up work for the hospital; that is, as patients leave hospital we aid them in re-establishment in the home, in the community, and occupation.

(2) We do field studies of the mental defective problem in certain areas.

(3) We supervise and treat certain government wards (defectives) in the community.

(4) We act as an out-patient child guidance clinic to serve schools, juvenile courts, children's aid societies, social agencies, and penal institutions.

In other words, we are a travelling social adjustment clinic.

Our Whitby clinic now regularly visits Oshawa, Lindsay, Peterborough, Port Hope, and Cobourg, and we have arrangements under way to hold regular clinics in Whitby town library. It is my desire to make clear to you that although we are seeing psychotic, prepsychotic and mentally defective persons, that our main object is to see any adult or child who has a social problem of any sort. We, as educated persons, must break down the prejudice that accompanies the voicing of a suggestion that anyone needs mental care. Let us remember that social adjustment is our object. Social adjustment aids in the striving after happiness, and happiness means mental health.

May I outline some of the problems that make for social maladjustment? In the school there is the pupil who is not adjusting properly to his school work, his contacts with his fellows or with his teacher. There are those in whom the natural fidgitness of childhood is over-accentuated, those who are a constant source of worry because of misbehaviour, those whose work is passable except in one especial subject. Of course, a certain amount of self-analysis is necessary before we can understand the classroom reaction of children, for we must always look for the good in children. A child is only as good as we expect him to be, and distrust breeds bad behaviour. I was dumbfounded not long ago on learning one teacher's attitude toward children. She said while talking of a certain boy who was a problem in her class, "Of course, after fifteen years of teaching I realise how much bad there is in children." Naturally this attitude was just the type of one to invite misbehaviour.

Part of our examination is a thorough physical one. It is indeed surprising the amount of physical abnormality that may be overlooked and the resultant difficulty misinterpreted. I think of one boy who was constantly being criticised at home, at school and line because of his posture. It had become so severe that he had few peaceful moments and was in consequence developing a paranoidal type of reaction, with bad behaviour as a result. We found on examination a definite curvature of the spine that made it impossible for him to stand or sit perfectly straight. This difficulty was explained to both teacher and parents; the boy was no longer criticised and he began to feel that he could go about without this constant nagging, so that gradually his whole attitude has changed. He has improved in his school work and his behaviour is better.

Another boy, because of physical deformity, had begun to wet himself. He became very much upset about this, became withdrawn, would not play with the other children, and gradually as inattentiveness increased the quality of his school work dropped off. After the clinic had seen him and had arranged for a slight operation he lost his feeling of insecurity and inferiority and began again to take an active interest in sports and especially in his school work. He now stands well up in his class.

Still another boy was found to suffer from badly infected tonsils, which

were constantly discharging pus. This boy following operation changed in disposition and improved in his studies so that he stood sixth in his class. At normal school attention is drawn to difficulties in vision and hearing. I fear that sometimes these difficulties are forgotten, for several children lately when found to have poor sight or hearing have been placed near the front of the classroom and have surprised their teachers by their improvement.

The physical side of a child's make-up is vastly important, but there are other factors to be considered too. In the classroom the teacher sees only one side of the child's life, but all the rest of his life outside of school colours his schoolroom reaction. We in the clinic attempt to get a long section picture of his whole life, his home, his school and his play. More and more we realise the important part that environment plays; broken homes, quarrelling parents, realisation of poverty or financial difficulty in the home, all these things go to make for feelings of insecurity in the child. Inferiority, too, is developed by comparison; one child smarter than the other in the parents' opinion and that constant remark, "Why don't you do as well as your sister or your brother?" The child who is considered the best in the class because he stays in at recess to work for the teacher may really be running away from the necessity of meeting the other children at play. This usually is a way of not facing life's situations squarely and not facing them adequately.

Then a word about speech defect. We at last have learned that children must be taught to talk. But unfortunately even yet many educated people do not realise this fact, and what a source of insecurity and inferiority this difficulty of faulty speech can present to the child. Speech defect makes him timid, self-conscious and shy, and in consequence his school work and his social reaction is inadequate.

Time will not permit me to further enlarge on the type of difficulties which we hope to aid. Suffice it to say that in all fairness to our school children, any retardation or behaviour difficulty in the classroom should be carefully investigated, and any problem in adult life that lends to social maladjustment and consequent lack of happiness also demands of us careful investigation. It is our wish in the mental health clinic to work with physicians, nurses, teachers and all social agencies to aid in the establishment of mental health in all that come to us; in other words, our greatest desire is *happiness for all.*

THE VICTIM

"The law of heredity winds like a red thread through the history of every criminal, of every epileptic, eccentric and insane person."

AUGUST FOREL, M.D., Ph.D., LL.D.

I did not sow myself this thing that I must reap,
Or bind the sheaves that make my load.
Tillage of rotten soil has claimed its debt,
And someone dared to hew for me the songless road.

Someone who breathed before me will face God's rebuke
(His tender eyes will anger when he speaks of me),
And I shall rise from out a madman's grave to cry
Shame on the lust that cared not for the lives to be!

V. V. R.

Employment for Nurses

Some time ago a request was made to the secretary of each provincial association of registered nurses, in an effort to obtain for the *Journal* an account of what is being done in each province to assist in relieving unemployment among nurses.

The Secretary of the Association of Registered Nurses in the Province of Quebec has contributed the following report:

There is very considerable unemployment among nurses in Quebec Province, but no section carries the serious problem in this regard as does the group in Montreal, where the daily average of unemployed registered nurses for the past year has been over four hundred. In an effort to overcome this unhappy situation, all hospitals throughout the province are endeavouring to take care of their own graduates, and no nurse is occupying a position unless she is obliged to earn her living. The Montreal Graduate Nurses Association, operating the Central Registry, has been conducting a loan fund for members for nearly two years, and every effort is being made to provide an even distribution of calls, so that all those registered for duty may share equal opportunities.

Several of the French hospitals are employing graduate lay nurses on their staffs, for the first time, and others have increased their numbers.

All English hospitals have increased the number of graduates on their staffs, especially in private wards.

One hospital has provided a scheme whereby their graduates may do hourly nursing on the hospital staff, fitting in where duty is heaviest, thus assisting the individual nurses and the hospital administration.

In another, for the past two years, the student nurses have been withdrawn from the private wards and graduates only employed: graduates are also engaged for various phases of night duty.

A third hospital is providing increased general ward duty for its graduates, funds for which have been supplied by the members of regular hospital nursing staff (large in number), who are each contributing one day's salary per month for a period of six months, to be increased if necessary. The amount realised in this way will prove to be very considerable, and the number of nurses given at least a limited amount of duty quite large.

In a fourth, the Board of Management is co-operating most sympathetically with the unemployment situation by having given the Superintendent of Nurses *carte blanche* to increase the graduate nurse staff whenever and wherever advisable. This hospital, having considerably increased the number of student nurses in affiliation for special courses during the past year, is replacing vacancies caused thereby with graduates instead of increasing the number of the student group. A special effort was also made in this hospital at Christmas time to place as many out-of-town nurses on duty in the hospital as possible, so that they might share the Christmas spirit. This hospital has also created a special fund from which graduates may obtain loans if they desire.

The special hospitals, viz.: obstetrics, pædiatrics and communicable diseases, have materially increased the number of graduates on general duty.

ANNUAL MEETINGS

Alberta Association of Registered Nurses, Edmonton, March 22nd and 23rd, 1932.

Saskatchewan Registered Nurses Association, Saskatoon, March 31st and April 1st, 1932.

News Notes

ALBERTA

The annual meeting of the Alberta Association of Registered Nurses will be held in Edmonton on March 22 and 23, 1932. Miss Jean E. Browne, Director of Canadian Red Cross, will be the guest speaker.

BRITISH COLUMBIA

VICTORIA: The annual meeting of the Victoria Graduate Nurses Association was held at St. Joseph's Hospital Nurses Home on February 2, 1932. There was a large and representative gathering present. After the usual monthly business was dispatched, the yearly reports were read, and these were found quite encouraging, considering the financial depression and the unemployment situation. A hearty vote of thanks was tendered the local hospitals for their kind hospitality throughout the year. A committee was appointed to arrange for some more tangible way of showing the appreciation of the Association for this courteous hospitality A Kardex system has been installed by the Association, which, it is hoped, will facilitate the handling of the Registry. At the close of the meeting a pleasant social hour was spent and dainty refreshments were served under the convenership of Miss Ellen Cameron. The officers for 1932 are: President, Miss Meta Hodge; First Vice-President, Miss Eunice Milloy; Second Vice-President, Miss Dorothy Frampton; Secretary, Miss Estella Herbert; Treasurer, Miss Winnifred Cooke; Executive, Misses Ethel Morrison, Frances Hooke, C. M. Kenny, Helen Cruickshank, Ellen Cameron; Sick Benefit Convener, Miss C. M. Kenny.

The sincerest sympathy of the Association is tendered to Miss Gertrude Curry, of the Royal Jubilee Hospital staff, in the loss of her father.

MANITOBA

ST. BONIFACE HOSPITAL: At the annual meeting of the Alumnae Association, held in the Nurses Residence, the following officers were elected: Hon. President, Sister Mead; Hon. Vice-President First, Sister Krause; President, Miss E. Shirley; First Vice-President, Miss E. Perry; Second Vice-President, Miss H. Stevens; Secretary, Mrs. Stella Gordon Kerr; Treasurer, Miss A. Price. The Alumnae held their annual social benefit evening in the Picardy Salon, Winnipeg, on February 8, 1932.

At the February meeting of the Alumnae, held in the Nurses Residence, lantern slides were shown on "The Preparation of Serum". This was followed by a very interesting and instructive talk on Cancer and Radium, by Dr. R. W. Richardson.

BRANDON: The Graduate Nurses Association met on February 6th, at the home of Mr. E. Fotheringham. The programme was under the direction of the Married Nurses' Group. A number of business items were disposed of and a very interesting and comprehensive account of the recent convention of the Manitoba Association of Registered Nurses was given by Miss Eva McNally. This was followed by a pleasing paper on Dresden china given by Mrs. B. E. Hull. During the social hour a pleasant feature was the presentation of a basket of flowers to Mrs. S. J. S. Peirce, whose birthday it was.

NEW BRUNSWICK

CHATHAM: On the evening of January 14th the Nurses Alumnae of the Hotel Dieu School of Nursing gathered at the hospital for a pleasant "At Home," to which they had been invited by Mother Superior and the nursing staff. All those whose duties would allow accepted the invitation, and at 8 p.m. a fairly good number took part in the business meeting, at which officers for the coming year were elected: President, Miss Clora Skidd; Vice-President, Miss Florence Fitzpatrick; Secretary, Miss Annie Hill; Treasurer, Miss Olive McBride. Following this meeting, those present adjourned to the Seniors' reception hall of St. Michael's Academy, where arrangements had been made for an enjoyable evening, featured mainly by music, vocal and instrumental. The social hour was opened by Reverend J. F. Ryan of St. Thomas College, with an excellent speech on the significant characteristics of an Alumnae in relation to its Alma Mater. In extending a vote of thanks to the speaker, Mrs. J. McMahon, the retiring president, addressed a very earnest appeal to Father Ryan to accept the office and duties of Spiritual Adviser to the Alumnae of Hotel Dieu, which request was most graciously acceded to.

The Alumnae deserves much praise for the very tangible way in which it expresses its loyalty to the hospital and school. This is evidenced by the many little gifts of practical utility that so frequently find their way to the departments of the hospital. Recently the Children's ward was opened, and in a remarkably short time the empty room was changed into an attractive ward for five children. A metal tablet on the ward door informs the passing visitor that this was the work of the Alumnae of Hotel Dieu.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in February, 1932, were 902, fifty-two less than in January, 1932.

APPOINTMENTS

GENERAL HOSPITAL, HAMILTON: The Misses Daisy Hamilton (1929) and Olive Phillips (1930) have accepted positions on the staff of the Infants' Home, Hamilton. Overseas Sister Catherine Irwin is on the staff at St. Peter's Infirmary.

CHATHAM: Miss Viola Dyer, as Assistant Superintendent of the Public General Hospital, Chatham, following Miss D. Thomas' resignation.

ONTARIO DEPARTMENT OF HEALTH: Miss Maude Weaver, 1931 graduate of Course II, Public Health Nursing, University of Toronto, is doing public health work in Chapleau. Miss Weaver has just completed a month's work in the schools of Orangeville.

Miss Joan Coutts (St. Michael's Hospital, Toronto, 1931; Summer Course in School Nursing, 1931) was recently appointed as School Nurse for the King George and George Syme Schools in York Township.

Mrs. Lillian McLean (Owen Sound General and Marine Hospital, Summer Course in School Nursing, 1929) has been appointed to the position of School Nurse in the Lincoln County Health Unit, following the resignation of Miss Maude Wagstaffe (Wellandra Hospital, St. Catharines).

Miss H. Elizabeth Smith of the staff of the Ontario Department of Health, is taking the four months' course at the Mothercraft Centre, Toronto.

DISTRICT 1

CHATHAM: The annual banquet of the Public General Hospital Alumnae Association was held in the William Pitt Hotel on January 22, 1932, with seventy-three in attendance. Among those present was Mrs. Henry Conn (Sara Resterick, 1895), now of Sarnia, a member of the first graduating class of this hospital. Rev. Dr. Fulton, of First Presbyterian Church, was the speaker of the evening.

At the December meeting of the Alumnae Association, Miss D. Thomas was elected President, Miss Katherine Cracknel, Recording Secretary, and Miss E. Mumery, Treasurer.

WINDSOR: At the recent annual meeting of the Florence Nightingale Association of the Border Cities an appreciable increase in membership was reported. The Association had been most active during 1931 in local professional, social and philanthropic work. Members met weekly to sew for the Women's Relief Committee, while among projects supported were the local V.O.N., the Goodfellows, Christmas cheer for sick members and the Association's room at the Metropolitan Hospital. A cordial invitation is extended to nurses who are newcomers to the Border to attend meetings, which are held the first Tuesday of every month.

DISTRICT 2

KITCHENER: The winter meeting of District No. 2, Registered Nurses Association of Ontario, was held on January 28th at St. Mary's Hospital, Kitchener. The attendance of one hundred and twenty-five showed the ever-increasing interest in the Association. Nurses were present from Fergus, Ayr, Tillsonburg, Woodstock, Galt, Guelph, Preston, Kitchener, Waterloo, Simcoe, Freeport, St. Clements and Brantford. Dr. A. T. Turner, chief of the Medical Staff of St. Mary's Hospital, extended to the nurses a very cordial welcome, and spoke a few words on the trend of nursing of the present day. The speakers for the afternoon and their topics were as follows: Dr. J. W. Fraser, M.O.H. Kitchener, "Typhoid Fever"; Dr. A. E. Broome, Guelph, "Surgery in Tuberculosis"; and the Rev. Father Mayer, Waterloo, who spoke briefly on the danger of nurses becoming too materialistic and failing to realise their professional responsibility to the mind as well as the body of the patient. These three excellent addresses were greatly appreciated by the audience and a hearty vote of thanks was extended to the speakers by Miss M. Bliss, Guelph. High tea was served by the members of the St. Mary's Alumnae Association, after which the meeting convened for a short session to finish up the routine business.

BRANTFORD: Recent visitors were: Miss Edna Moore, Chief Public Health Nurse, Province of Ontario; Miss Maude Hall, Assistant Superintendent, Victorian Order of Nurses for Canada; and Miss Margaret MacCormack, Superintendent, Stevenson Memorial Hospital, Alliston, Ontario.

The annual meeting of the Florence Nightingale Club was held at the home of Miss Cleator on January 11th. Officers were elected as follows: President, Mrs. J. N. Mitchell; Secretary. Miss T. Dawson; Treasurer, Miss M. McMillan. The February meeting was held at the home of Mr. Diack on February 1st.

The aim of the Brantford Red Cross Home Nursing Committee for the current year is that 150 young women will receive instruction in home nursing. Ably organised by Miss Nellie Yardley, Reg.N., six classes, with a total attendance of 120, are now in progress, the members being drawn from church organisations, office staffs and the Girl Guides. The nurse teachers are: Misses D. Arnold, G. V. Westbrook, F. Batty, T. Dawson, C. Good and H. Kerr. The lectures on communicable diseases, emergencies, and infant care are given by local physicians. The dietetic lectures are given by Miss H. Murison, dietitian, Brantford General Hospital.

Sponsored by the local branch of the Victorian Order of Nurses, and under the instruction of Miss H. Kerr, thirty-two little girls are receiving mothercraft lessons.

OWEN SOUND: The regular monthly meeting of the Nurses Alumnae will be held at the home of the Misses Stewart, when plans will be made for the district meeting to be held in Owen Sound in June.

The sympathy of the local nurses is extended to Miss Schaultz, assistant superintendent of General and Marine Hospital, on the death of her mother.

GUELPH: Several carloads representing the General Hospital, St. Joseph's Hospital, and the Homewood Sanitarium, attended the meeting of District No. 2, held at St. Mary's Hospital, Kitchener, on January 28, 1932.

DISTRICT 4

GENERAL HOSPITAL, HAMILTON: Under the joint auspices of the Hamilton Medical Orchestra and the Nurses Alumnae Association of the H.G.H., a very delightful dance and

bridge was held in the ballroom of the Royal Connaught Hotel on the evening of January 27th. The affair was one of the most successful sponsored by the two societies.

The many friends of Miss Shirley Shearsmith (1930) will be glad to know that she is able to return home after her long illness at Mt. Hamilton Sanatorium.

DISTRICT 5

TORONTO: The seventh annual meeting of District 5, R.N.A.O., was held in Osler Hall, Academy of Medicine, Toronto, on January 21st, 1932. Miss Ruby Hamilton, Vice-Chairman, presided in absence of Miss Rahno Beamish owing to illness, and one hundred members were present. No reports were presented by Chairmen of the Nursing Education or Private Duty sections, but Miss Vera Allen of the Public Health section reported having arranged with the Victorian Order of Nurses for Canada to conduct a Maternal Care Institute sponsored by her section to take place in Toronto on February 4th and 5th. The annual reports of Membership, Programme and Permanent Education Fund Committees were presented before the election of officers for 1932, which resulted as follows: President, Miss Rahno Beamish; Vice-President, Miss Dorothy Mickleborough; Secretary-Treasurer, Miss Irene Wiers; Convener Nursing Education, Miss Alberta Bell; Convener, Private Duty Section, Miss Jennie Moore; Convener, Public Health Section, Miss Vera Allen; Councillors, Misses Elizabeth McWilliams, Oshawa; E. J. Johnston, Orillia; Isabel McEwen, M. E. Bullick, Jean Masten and Edith Scott, Toronto.

Dr. Oskar Klotz of the Banting Institute, Toronto, gave a very interesting lecture on the development of pathological laboratory work and described the various departments of the Institute.

The Community Health Association of Greater Toronto held a meeting in the auditorium of the Toronto Humane Society on Fenruary 17th. Dr. H. B. Speakman described the work of the Ontario Research Foundation, and Miss Laura Gamble presented a report of her work in connection with the Survey of Convalescent Care.

The many Toronto friends of Miss Edna Moore are delighted to welcome her on her return from New York, where she was attached to the N.P.O.H.N., to take over her new work as Chief Nurse with the Provincial Department of Health.

The Maternal Care Institute arranged by the Public Health Section of District 5, R.N.A.O., and conducted by Miss Ethel Cryderman, Ontario Supervisor of the Victorian Order of Nurses for Canada, was held in the class room of the Toronto General Hospital on February 4th and 5th. The attractive rooms on the fifth floor of the West Residence were, for the third time, placed at the disposal of the nurses attending the Institute, in the usual hospitable style of the T.G.H. Twenty-two nurses were registered for the Institute and forty-five attended the evening lecture on "Nutrition in Pregnancy," given by Miss Marjorie Bell, nutritionist, with the Montreal Branch of the Victorian Order. Dr. W. B. Hendry, Professor of Obstetrics, University of Toronto, who was present at the closing session to take part in discussion and answer questions, contributed a good deal of valuable information and advice as a conclusion to a very successful Institute. Miss Marion Morrison expressed thanks to Miss Cryderman for the energy and enthusiasm which characterised her conduction of the sessions.

OSHAWA: At the annual meeting of the Alumnae held at the Nurses' Residence, Oshawa General Hospital, January 4, 1932, the following officers were elected: Honorary President, Miss E. McWilliams; President, Mrs. M. Yelland; Vice-President, Miss J. McIntosh; Second Vice-President, Mrs. D. Redpath; Secretary, Miss H. Batty; Treasurer, Miss J. Cole; Corresponding Secretary, Miss H. Hutchinson; Assistant Corresponding Secretary, Mrs. W. Luke; Visiting Convener, Mrs. M. Canning; Social Convener, Miss I. Cook; Membership Convener, Miss J. Cole; Private Duty Convener, Miss M. Quinn; Programme Convener, Miss L. Hinton; Hospital Auxiliary Representatives, Mrs. M. Canning, Mrs. B. A. Brown, Mrs. Hare. Miss A. Scott was in charge of the meeting. Mrs. M. Yelland gave a report of the activities of the past year, and the treasurer, Miss J. Cole, in her financial statement showed that the Alumnae had a good balance on hand.

WOMAN'S COLLEGE HOSPITAL, TORONTO: The January meeting of the Alumnae will always hold fond memories for the members present, as they again saw the "School's everlasting torch" taken up, to be carried far into Central Brazil by Miss Jennings of the Association. The members wished her bon voyage, and presented her with a travelling rug. Miss Fleming, of St. George Street School, addressed the meeting on the subject of "Training Children from the Age of Two to Five Years," and answered any questions raised by the members.

In February, Mrs. Irving Robertson spoke on the "Art of Mothercraft in the Community".

Miss Bankirby, 1923, has established on Avenue Road, an attractive foodshop called the Butler's Pantry, and which is artistically decorated in black and white.

Recently, Miss Eleanor Clarke entertained at a very pleasant tea in honour of Miss Bolton, 1924, who is serving in the Pine River District under the M.G.C.C. Among those present were Mrs. Raymor, Misses Henry, Hawkes, Roberts, Allan and Collier.

The Alumnae extend their sincerest sympathy to Miss Meiklejohn on the loss of her revered mother.

DISTRICT 6

PORT HOPE: Port Hope has two very active Men's Clubs, The Rotary and The Lions. Both clubs are doing excellent work for their fellow citizens. Crippled children are helped by expert orthopedic advice and surgery.

Children's throats receive attention. Where parents cannot meet the expense themselves, the Rotarians have helped. Local dentists have inspected the teeth of all the children at the schools. The Lions Club made arrangements with the Department of Health, who sent Dr. McKenzie Smith and Miss Lefler, a nurse, to inspect all school children's eyes, also free of charge to the parents. The Town Parks have been greatly improved, and the acreage increased by the Rotarians. The Port Hope Hospital is open every two weeks to Dr. Montgomery, who has care of the Mental Health of the citizens of the town and surrounding country. Dr. Montgomery and Miss Aikenhead and their staff will see anyone who wishes to consult them, if they make an appointment with the superintendent of the Hospital.

LINDSAY: At a meeting of Chapter 3' District 6, held at the Ross Memorial Hos" pital, Lindsay, on January 26th, there was a good attendance. After a concise talk on the aims and work of the Association given by the President, six of the nurses applied for membership forms. One of the pleasing features of the afternoon's programme was a talk from Dr. White of Lindsay on his trip to Alaska.

DISTRICT 8

OTTAWA: About two hundred members of District 8, R.N.A.O., held an interesting all-day meeting in the Chateau Laurier on January 28th. Reports were presented, addresses of interest given and officers elected for the year. Miss Alice Ahern presided. The morning meeting was devoted to business relative to the Association and the presentation of reports covering the various activities of the groups. In the afternoon Dr. W. J. Stevens, Ottawa, gave a very interesting paper, illustrated by lantern slides, on "Obstetrics and Rectal Anaesthesia," and Dr. Norman Guiou, Ottawa, an illustrated lecture on "Operative Precedure in Obstetrics". A splendid demonstration was given by Miss K. McIlwraith and Miss Helen Stewart of the Ottawa branch of the Victorian Order of Nurses on "Preparations for Confinement in a Home". Miss Dorothy Percy was elected Chairman, Miss Blanche Anderson Vice-Chairman, and Miss A. G. Tanner was re-elected Secretary-Treasurer. Councillors elected are: Misses E. C. McIlwraith, Jean Church, Mary Slinn, Ruth Pridmore, Ella Rochon, and Amy Brady.

QUEBEC

WESTERN HOSPITAL, MONTREAL: The annual meeting of the Alumnae was held in the Nurses' Home, January 11th, at which the officers were elected for 1932. After considerable business was taken up, refreshments were served in the Lounge. In December the Alumnae took charge of a family of seven, providing clothing, Christmas dinner and cheer, which seemed to be greatly appreciated by them.

WOMEN'S GENERAL HOSPITAL, MONTREAL: The annual meeting of the Alumnae Association was held on January 20, 1932. Reports of the President and Treasurer were read, and Miss George, Honorary President, gave a short address. The members extend their deepest sympathy to Miss Grace Wilson in her recent bereavement, on the death of her sister.

SHERBROOKE: An unusually interesting and largely attended meeting of the Eastern Townships Graduate Nurses Association was held at the McKinnon Memorial Building, on February 4th, when about twenty-five nurses gathered for their annual business session. A turkey dinner was served at 8 p.m. The table decorations were most artistic and unusual. The Association's colours, blue and yellow, with several dolls dressed as nurses and candles in silver holders were used. The President, Miss Stevens, presided. After dinner, business was transacted, reports read and officers elected.

SASKATCHEWAN

The annual meeting of the Saskatchewan Registered Nurses Association is to be held in Saskatoon, March 31 and April 1, 1932. A study of the Report on the Survey of Nursing Education in Canada will occupy the attention of the delegates.

REGINA: A meeting of the Grey Nuns' Hospital Alumnae Association was held on February 11 at the home of Miss Rotner. The following officers were elected for 1932: Hon. President, Sister O'Grady; President, Mrs. Oberhaffner; First Vice-President, Miss McGrath; Second Vice-President, Miss Rotner; Secretary-Treasurer, Miss V. Harrop, 2164 Angus St., Regina; Executive, Mrs. Tanney, Mrs. Fyfe, Misses Gropp and McQuatt; Visiting Committee, Mrs. McKeevor, Misses Mueler and Patterson; Membership Committee, Miss McQuatt, Mrs. Gall, Miss Olive Keys; "The Canadian Nurse" Representative, Mrs. A. Tanney, Department of Public Health, Regina; Local Council of Women, Mrs. Oberhaffner. Mrs. A. Tanney (1922), of Department of Public Health, addressed the meeting on Public Health Nursing and referred to a new post-graduate course, namely, "Aviation in Nursing". She also recommended each nurse to subscribe to "The Canadian Nurse". Arrangements were partly completed for entertainment for the 1932 Graduating Class. Five dollars was donated to the Salvation Army Tea and $3.00 for affiliation to the Local Council of Women. Miss Sawyer (1929) is taking a post-graduate course at the Sanatorium, Prince Albert. Miss Irons (1929), former president of the Alumnae, left recently for the East, where she entered the Sisterhood of St. John the Divine of the Anglican Church. Miss Jansen (1929) of Morse, returned from the Royal Victoria Hospital, Montreal, after completing a course in Obstetrics.

C.A.M.N.S.

SASKATOON: On January 28, 1932, there passed away in Victoria, B.C., one of Saskatoon's best known and greatly esteemed citizens, Mrs. J. D. Macdonald, formerly Nursing Sister Harriet Graham, of New Glasgow, N.S., and graduate of St. Luke's Hospital, New York City. Volunteering for overseas service in August, 1914, she accompanied the first Canadian contingent to France, where at No. 1 Casualty Clearing Station she served as Matron for the greater part of the war. Later, in recognition of her splendid services, she was decorated by His Majesty King George with the Royal Red Cross, first rank.

Returning to Canada in 1919, Nursing Sister Graham served for two years as Matron of the Military Hospital at Burlington, Ontario.

Since her marriage her home had been in Saskatoon, where she took a prominent part in women's work and interests, having served as a member of the City Hospital Board and as President of the local branch, Victorian Order of Nurses. Endowed with exceptional executive and administrative ability and forceful but most winning personality, Mrs. Macdonald endeared herself to all those with whom she came in contact, making many friends in Saskatoon as she had done in home and professional life of earlier days. The sympathy of her many friends is extended to her husband, her two sisters and brother.

TORONTO: The officers and executive of the Overseas Nurses Club of Toronto entertained at tea at the home of the President, Mrs. Jack Bell, on February 6th. Miss Edith Campbell, A.R.R.C., Hon. President, received with Mrs. Bell, and over two hundred members filled the rooms, renewing old friendships and talking over old times. Among the past presidents pouring tea at the attractive table, with its centre of spring flowers, were Mrs. Arthur Scott and Mrs. R. Robertson (Pauline Ivy). Matron Hartley, A.R.R.C., was unable to be present owing to the serious illness of Miss Catherine Graham, who passed away later on in the day at Christie Street Hospital. Miss Graham went overseas in August, 1917, where she was attached to McGill Unit and served in France and England until her return to Canada in August, 1919. After some time spent at the officers' hospital on Spadina Ave., and at the Brant Hospital, Burlington, she was attached to the staff at Christie Street Hospital, where she was held in high esteem by patients and staff. Miss Graham served on the Executive of the Overseas Club of Toronto, and her interest and support will be missed by many of its members.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

BRYANT—On October 30, 1931, at Sherbrooke, P.Q., to Mr. and Mrs. Clifford Bryant (Isobel MacCauley, Sherbrooke Hospital, 1928), a daughter, Jacquelin Ann.

CLARKE—On February 3, 1932, at Chatham, Ont., to Mr. and Mrs. Fred Clarke (Eleanor Sherratt, Public General Hospital, Chatham, 1917), a son, Charles Fredrick.

COLLINS—On February 8, 1932, at St. Boniface, Man., to Mr. and Mrs. H. Collins (T. Shelton, St. Boniface Hospital, 1924), a son.

COLQUETTE—On January 4, 1932, to Mr. and Mrs. Bruce Colquette (Ina M. Burnett, Toronto Western Hospital, 1929), a son.

COON—On January 11, 1932, at Norfolk, Virginia, U.S.A., to Dr. and Mrs. Willard Coon (Lulu M. Docherty, Toronto Western Hospital, 1922), a daughter.

FLOCK—On January 2, 1932, at Chatham, Ont., to Mr. and Mrs. Earl Flock (Mildred Riseborough, Public General Hospital, Chatham, 1930), a son, Earl Douglas.

FOURNIER—On January 18, 1932, at St. Boniface, Man., to Mr. and Mrs. Fournier (Alma Gauthier, St. Boniface Hospital, 1923), a son.

FRIESEN—In Regina, to Mr. and Mrs. Ed. Friesen (Cecelia Fahlman, Grey Nuns' Hospital, Regina, 1930), a son.

GILLESBY—On January 16, 1932, at Owen Sound, Ont., to Mr. and Mrs. James Gillesby (Grace Rusk, Owen Sound General and Marine Hospital, 1923), a daughter.

HARDING—On December 26, 1931, at Montreal, to Mr. and Mrs. Hugh Harding (Muriel McCollum, Montreal General Hospital, 1923), a daughter, Mary Lou.

JONES—On December 11, 1931, at Montreal, to Mr. and Mrs. L. E. P. Jones (Jean Crate, Ottawa Civic Hospital, 1927), a son.

KINNEY—On November 14, 1931, at Cleveland, Ohio, to Mr. and Mrs. Leroy Kinney (Myrtle Last, Kitchener and Waterloo Hospital, 1923), a son.

McARTER—Recently, at Scotsguard, Sask., to Mr. and Mrs. McArter (Marian Weeks, Grey Nuns' Hospital, Regina, 1922), twins.

O'SULLIVAN—On January 14, 1932, at St. Boniface, Man., to Mr. and Mrs. J. O'Sullivan (Gladys Walch, St. Boniface Hospital, 1928), a son.

SMITH—On December 31, 1931, at Chatham, Ont., to Mr. and Mrs. Murray Smith (Harriet Furness, Wellesley Hospital, Toronto, 1921), a daughter, Helen Christine.

URE—In November, 1931, to Mr. and Mrs. Ure (Corinne Glenny, Hamilton General Hospital, 1926), a daughter.

ZOPPI—On January 10, 1932, at Ottawa, to Mr. and Mrs. Fred R. Zoppi (Evelyn A. Pink, Ottawa Civic Hospital, 1928), a daughter.

MARRIAGES

BAITZ—WILSON—On December 31, 1931, at Ottawa, Audrey Chalmers Wilson (Ottawa Civic Hospital, 1927) to Charles C. G. Baitz, of Union City, N.J.

CASSELL—DUCKWITH—On January 30, 1932, at Oshawa, Emily Edythe Duckwith (Oshawa General Hospital, 1926) to Conyn Robert Cassell, of San Diego, California.

DREW—MILLER—On December 29, 1931, at Port Parry, Ont., Retta Gertrude Miller (Oshawa General Hospital, 1930) to E. Willis Drew, of Oshawa.

ERB—MEYSCHEIN—On September 28, 1931, at Stratford, Ont., Selma Meyschein (Stratford General Hospital, 1927) to Irvin E. Erb, of Kitchener, Ont.

GILLAN—BOURKE—On January 28, 1932, at Pakenham, Mary Bourke (Ottawa Civic Hospital, 1931) to Matthew W. Gillan.

GOLDSMITH—SEGUIN — On September 25, 1931, in Montreal, Minnie A. Seguin (Woman's General Hospital) to L. Goldsmith, Sr.

KERR—KEUNEMAN—On January 30, 1932, Irene Keuneman (St. Boniface, 1924) to Mr. Melvin H. Kerr, of Winnipeg.

MALONE—DENNIS—On December 23, 1931, Winifred Dennis (Hamilton General Hospital, 1931), to A. F. Malone, Principal of the Continuation School, Port Burwell, Ont.

PETITE—STAPLES—On January 5, 1932, at Montreal, Myrtle Staples (Montreal General Hospital, 1929) to James Petite.

WILSON—McNICHOL—On November 4, 1931, at Owen Sound, Ont., Mildred McNichol (Owen Sound General and Marine Hospital, 1923) to Robert John Wilson, of Anten Mills, Ont.

GRADUATE NURSES ASSOCIATION OF BRITISH COLUMBIA

(Incorporated 1918)

An examination for title and certificate of Registered Nurse of British Columbia will be held April 13th, 14th and 15th, 1932.

Names of candidates for this examination must be in the office of the Registrar not later than March 14th, 1932.

Full particulars may be obtained from—

HELEN RANDAL, R.N., Registrar,
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DEATHS

DOWN—On January 9, 1932, at Tisdale, Sask., Elda Laurel Down (St. Boniface Hospital, St. Boniface, Man., 1923).

GRAHAM—On February 6, 1932, at Christie Street Hospital, Catherine Graham, formerly attached to the McGill Unit, Canadian Army Medical Corps, and later at Brant Hospital, Burlington, and Christie Street Hospital, Toronto.

KRUGER—On January 26, 1932, at Toronto, Margaret E. Code (Toronto Western Hospital, 1927), wife of Dr. W. Cecil Kruger.

LANGDALE—On February 11, 1932, at Manitoba Sanitarium, Ninette, Mrs. F. E. Langdale (Maude Moulton, Sherbrooke Hospital, Sherbrooke, Que., 1900), member of the nursing staff, Winnipeg School Board, Winnipeg, Man.

MOLLISON—Suddenly, in Toronto, Miss A. J. Mollison, Hamilton General Hospital, 1927.

MACDONALD—On January 28, 1932 at Victoria, B.C., Mrs. J. D. Macdonald, formerly Nursing Sister Harriet Graham, of New Glasgow, and graduate of St. Luke's Hospital, New York City.

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Those wishing to write must apply for forms, etc., to the Registrar, and all applications must be in the office of the Association before April 1st. No application can be considered after that date.

E. FRANCES UPTON, R.N., Executive Secretary and Registrar, Room 221, 1396 St. Catherine Street West, Montreal, P.Q.

EXAMINATIONS FOR REGISTRATION OF NURSES IN NOVA SCOTIA

are to take place 18th and 19th May, 1932. Requests for application forms should be made at once and form returned before April 18, 1932, together with registration fee of $10.00, and, if graduated, diploma of school. No undergraduates may write unless they have passed successfully all final Training School examinations and are within six weeks of completion of period of training of their school.

L. F. FRASER, Registrar, 10 Eastern Trust Building, Halifax, N.S.

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Meetings—Second Wednesday of each month, 8 p.m., St. Boniface Nurses Residence.

A.A., WINNIPEG GENERAL HOSPITAL

Hon. President, Mrs. W. A. Moody, 97 Ash St.; President, Mrs. J. A. Davidson, 39 Westgate; First Vice-President, Mrs. S. Harry, Winnipeg General Hospital; Second Vice-President, Miss I. McDiarmid, 363 Langside St.; Third Vice-President, Miss E. Gordon, Research Lab., Medical College; Recording Secretary, Miss C. Briggs, 70 Kingsway; Corresponding Secretary, Miss M. Duncan, Winnipeg General Hospital; Treasurer, Mrs. H. I. Graham, 99 Euclid St.; Sick Visiting, Miss W. Stevenson, 535 Camden Place; Programme, Miss C. Lethbridge, 877 Grosvenor Ave., Membership, Miss A. Pearson, Winnipeg General Hospital.

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DISTRICT No. 10, REGISTERED NURSES ASSOCIATION OF ONTARIO

Chairman, Miss A. Boucher; First-Vice President, Mrs. F. Edwards; Second Vice-President, Miss V. Lovelace; Secretary-Treasurer, Miss M. Racey; Conveners of Committees: Nursing Education, Miss B. Bell; Public Health, Miss L. Young; Private Duty, Miss I. Sheehan; Publication, Miss M. Flannagan; Membership, Miss M. Sideen, Miss D. Elliott; Social: Miss E. Hamilton, Miss Chiver-Wilson, Miss E. McTavish; Representatives to Board of Directors Meeting, R.N.A.O., Mrs. F. Edwards.

Meetings held first Thursday every month.

GRADUATE NURSES ASSOCIATION, KITCHENER AND WATERLOO

President, Miss K. W. Scott; First Vice-President, Mrs. Wm. Noll; Second Vice-President, Miss K. Grant; Secretary, Miss A. E. Bingeman, Freeport Sanatorium; Treasurer, Mrs. Wm. Knell, 41 Ahrens St. W.; Representative, "The Canadian Nurse," Miss E. Hartleib.

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A.A., BELLEVILLE GENERAL HOSPITAL

Hon. President, Miss Florence McIndoo; President, Miss E. McEwen; Vice-President, Miss E. Cryderman; Secretary, Miss B. Cryderman; Treasurer, Miss E. Wright; Flower Committee, Miss J. Thompson and Miss M. MacFarlane; Representative, "The Canadian Nurse," Mrs. J. Campbell.

Regular meeting held first Tuesday in each month at 7.30 p.m. at the Nurses Residence.

A.A., BRANTFORD GENERAL HOSPITAL

Hon. President, Miss E. Muriel McKee, Superintendent; President, Miss I. Marshall; Vice-President, Miss A. Hardisty; Secretary, Miss H. D. Muir, Brantford General Hospital; Assistant Secretary, Miss F. Batty; Treasurer, Miss L. Gillespie, 14 Abigail Ave., Brantford; Social Convener, Miss M. Meggitt; Flower Committee, Misses P. Cole and F. Stewart; Gift Committee, Mrs. D. A. Morrison, Miss K. Charnley; "The Canadian Nurse" and Press Representative, Miss E. M. Jones; Representative to Local Council of Women, Miss G. V. Westbrook.

A.A., BROCKVILLE GENERAL HOSPITAL

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A.A., CORNWALL GENERAL HOSPITAL

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A.A., GUELPH GENERAL HOSPITAL

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A.A., HAMILTON GENERAL HOSPITAL

Hon. President, Miss E. C. Rayside, Hamilton General Hospital; President, Miss Annie B. Boyd, 607 Main St. E.; Vice-President, Miss M. Buchannan, Hamilton General Hospital; Treasurer, Miss E. Bell, 1 Cumberland Ave.; Recording Secretary, Miss B. Aitken, 44 Victoria Ave. S.; Secretary-Treasurer Mutual Benefit Association, Miss L. Hannah, 25 West Ave. S.; Executive Committee, Mrs. N. Barlow (Convener), 211 Stenson St., Misses E. Baird, C. Chappel, M. Pegg, Mrs. E. Johnson; Programme Committee, Miss Mary Ross (Convener), Misses M. Watt, H. Baker, E. Davidson, J. Lenz, M Harvey, C. Currah, Blanche Pond; Flower and Visiting Committee, Miss Sturrock (Convener), Misses Squires, Blanchard, Burnett. Representatives to Local Council of Women, Mrs. Hess, Misses Harley, Buckbee, Burnett; Representative to R.N.A.O., Miss G. Hall; Representatives to "The Canadian Nurse," Miss Buscombe (Convener), Misses Strachan and Carruthers; Representative to Women's Auxiliary, Mrs. J. Stephen; Registry Committee, Mrs. Hess (Convener), Misses Nugent, Hack, Gringer.

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A.A., KINGSTON GENERAL HOSPITAL

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A.A., ORILLIA SOLDIER'S MEMORIAL HOSPITAL

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Regular Meeting—First Thursday of each month.

A.A., OSHAWA GENERAL HOSPITAL

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A.A., ST. LUKE'S HOSPITAL, OTTAWA

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Institute of Public Health
Faculty of Public Health of the
University of Western Ontario
LONDON

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A.A., GRACE HOSPITAL, TORONTO

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A.A., RIVERDALE HOSPITAL, TORONTO

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A.A., HOSPITAL FOR SICK CHILDREN, TORONTO

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A.A., ST. MICHAEL'S HOSPITAL, TORONTO

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Meetings will be held the second Tuesday in each month at 8 p.m. in the Assembly Room, Nurses Residence, Toronto Western Hospital.

A.A., WOMEN'S COLLEGE HOSPITAL, TORONTO

Hon. President, Mrs. H. M. Bowman; Hon. Vice-President, Miss Harriet Meiklejohn; President, Miss E. J. Henry; First Vice-President, Mrs. Scullion; Second Vice-President, Miss Eleanor Clark; Recording Secretary, Miss Jessie Wagner; Corresponding Secretary, Miss Grace Clarke, 46 Delaware Ave.; Assistant Secretary, Miss Margaret Free; Treasurer, Miss Bessie Fraser, 526 Dovercourt Rd.; Representatives to Central Registry, Misses A. Bankwitz, Lois Shaw; Representatives to District No. 5, R.N.A.O., Misses Isabelle Munns, Ella Flett; Representatives to Local Council, Misses D. Berry, T. Hawkes; Conveners of Committees, Sick, Miss May Roberts; Social, Miss Agnes McGregor; Councillors, Misses W. Worth, M. Chalk and V. Allen; Representative to "The Canadian Nurse," Miss E. E. K. Collier.

Meetings at 74 Grenville St. second Monday in each month.

A.A., CONNAUGHT TRAINING SCHOOL FOR NURSES, TORONTO HOSPITAL, WESTON

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GRADUATE NURSES ASSOCIATION OF THE EASTERN TOWNSHIPS

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Regular Meeting—Second Tuesday of January, first Tuesday of April, October and December.

A.A., CHILDREN'S MEM. HOSP., MONTREAL

Hon. President, Miss A. S. Kinder; President, Miss D. Parry; Vice-President, Miss M. Flanders; Secretary, Miss R. Paterson, 3498 Harvard Ave., N.G.D.; Treasurer, Miss H. Easterbrook; Representative, "The Canadian Nurse," Miss V. Schneider; Sick Nurses Committee, Misses H. Nutall, M. Plamondon; Social Committee, Misses A. McFarlane, A. Adlington, F. Black and G. Gough; Representative, Private Duty Section, Miss J. Wilson.

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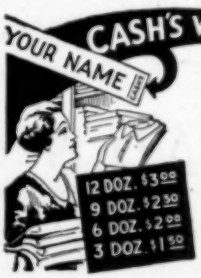

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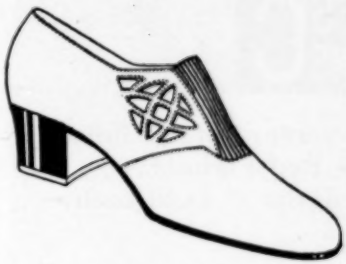

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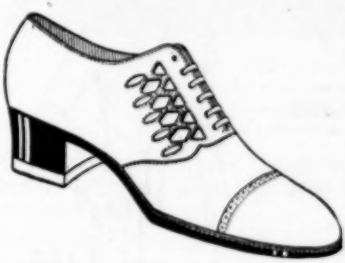

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